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July 1976 • Vol. 69 • No. 7 • Indianapolis

The JOURNAL OF THE INDIANA STATE MEDICAL ASSOCIATION

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respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

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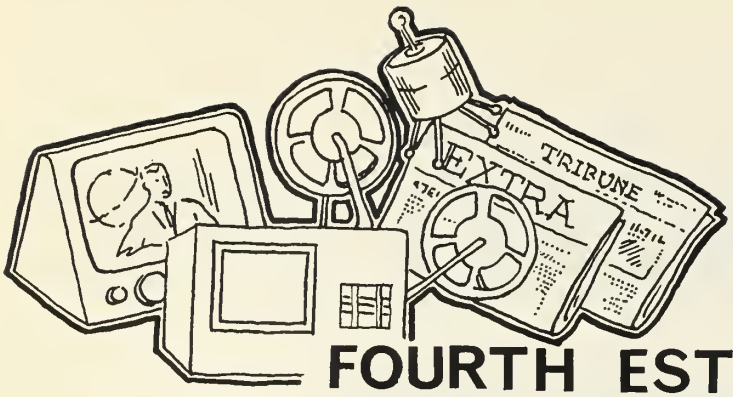
surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are in interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Economics of Medicine

The Council on Wage and Price Stability has reported that the cost of medical care has become an increasing source of inflation in the American economy.

Before the proponents for nationalized medicine rush to their nearest congressman waving a copy of the report in breathless excitement, they should ponder just why medical costs have risen.

There is, in short, a direct correlation between the rising costs of health services and the extent to which the federal government has involved itself in health care.

Until Washington intervened in health care, costs had been rising just about the same rate as the costs of other nonregulated consumer services.

But when Congress chose to become the Great Provider—through Medicare and Medicaid and heaven knows what other health subsidy programs—the costs shot up out of all proportion to standard inflation rates.

And no wonder.

There simply is no conventional restraint, either on the part of the health care supplier or the patient, to control costs.

While consumers spent $33.6 billion last year for health care in the nation, federal and state government laid out $49.9 billion, and insurance companies paid out another $27.3 billion.

That means for every $1 a patient paid out of his pocket into the American health system, government and insurers paid out another $2.

Such "free" service encouraged a rush on hospitals and doctors' offices by Americans eager to take advantage of subsidized medicine.

It is as though a supermarket advertised apples at $1 a pound, and shoppers knew they would have to pay only 33 cents per pound, and government would make up the difference at the checkout counter. Who wouldn't buy apples?

The rush required more hospital beds and staffs and buildings. The rush meant more medicine. And more nurses.

And, of course, more paperwork in quintuplet to report how government payments were justified.

Other factors were involved in medicine's 14% annual cost increase. Malpractice insurance leaped as much as 1,000% a year for hospitals, 500% for physicians.

Yet, at the heart of the increase is the absence of economic restraints on the part of the patient who would resist seeing a physician for minor complaints, and on the part of the physician who might be tempted to get his cut of the federal largesse.

That is sound economics.

But economics don't prevail in Washington. It's a sure bet that economic illiterates sitting in Congress will read the council's report, and suggest that government needs to get more involved in health care to drive prices down.—*The Muncie Press,* May 4, 1976.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** Robert **B. Greenblatt, M.D.**, and **D. H. Perez, M.D.**: "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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JULY 1976

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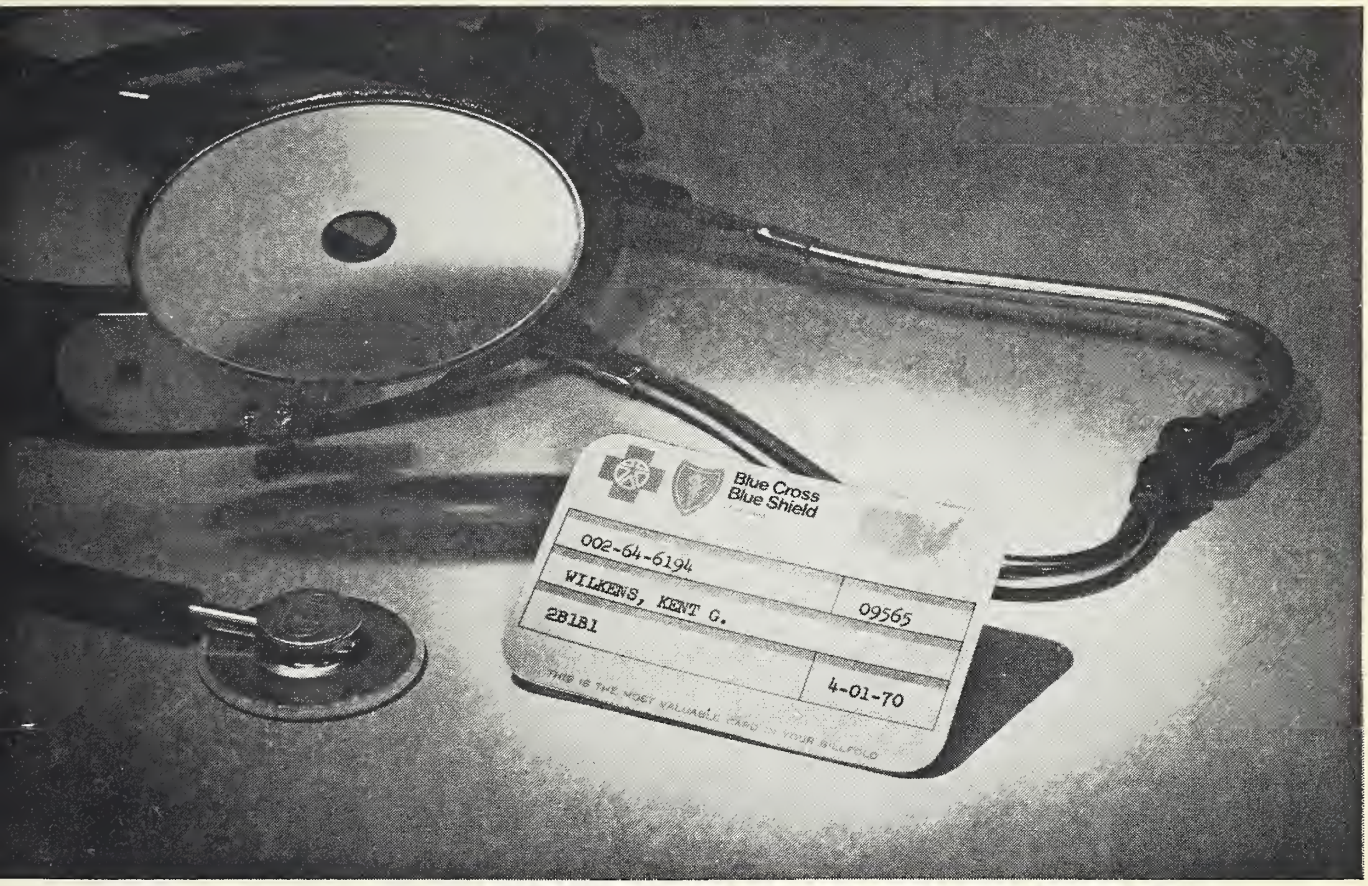
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11.	Richard G. Blair, Huntington	Fred Poehler, La Fontoine	Sept. 15, Huntington
12.	J. Robert Edwards, Auburn	Thomos A. Felger, Fort Wayne	Sept. 9, Fort Wayne
13.	John W. Luce, Michigan City	David L. Spalding, Mishawoka	Sept. 10, 1976, Michigon City



MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

THE SENATE HAS PASSED 64-11 A BILL broadening federal authority over clinical laboratories to include those engaged in intrastate operations and giving the government firmer standards control.

Under the legislation, HEW theoretically could apply the controls to the offices of individual physicians. The pertinent provision states that the HEW Secretary "may exempt" such offices. As a condition of such exemption, physicians who use their offices as labs as an adjunct for treating their own patients would have to describe the qualifications of nonphysician personnel who do lab work, how much they do, and the score each shows in any proficiency testing.

Sen. Carl Curtis (R.-Neb.) complained that "here the government is reaching down to the country physician's office . . . I say that we are removing from people the medical services that our society now provides by giving the federal government jurisdiction over them."

The bill, which now goes to the House where similar legislation is before the House Health Subcommittee, provides:

- **Federal licensing of all clinical laboratories. HEW would set standards and enforce them itself or delegate enforcement to states having statutory programs meeting federal criteria. Private nonprofit accrediting groups could be used to be help enforce standards if they meet federal requirements but no exemption from licensure to privately accredited laboratories is provided.
- **An advisory council with membership set at 12 persons, to include representatives of nationally recognized laboratory-accrediting bodies, directors of state laboratory-licensing programs, members of the public, and not more than three persons who are owners, operators or directors of laboratories.
- **HEW is authorized to waive for two years personnel standards for laboratory technicians employed in hospitals with fewer than 100 beds, if located in rural area.
- **An office of clinical laboratories to administer one set of uniform standards.
- **HEW may issue no license unless it has received from the applying laboratory "an accurate, itemized schedule of all current rates charged by the applicant for those laboratory services . . . and such other information as may be necessary, including full disclosures of any current contractural relationships, written or oral, between the applicant and physician respecting such services."
- **Laboratories found to be engaging in illegal financial abuses would be subject to revocation of licenses.

A RAND CORPORATION STUDY SAYS the amount people would have to pay in taxes under the disparate national health insurance (NHI) proposals before Congress wouldn't vary much and suggested this opens the door to compromise.

The study, financed in part by the government, was written by Bridger M. Mitchell, senior Rand economist, and William B. Schwartz, M.D., a Rand consultant and chairman of the Department of Medicine, School of Medicine, Tufts University.

The report said that the Administration's CHIP approach in its 1975 NHI bill provides a "surprisingly small" saving to middle and upper income taxpayers over the 1975 compromise Kennedy-Mills plan, although both provide essentially the same services.

The old Nixon Administration bill and the defunct Kennedy-Mills bill each would require total tax revenues of some $45 billion to fund the health care of people under 65. The Rand team said the labor-supported Kennedy-Corman proposal would require $68 billion, and the Long-Ribicoff bill, $16 billion.

Financed by payroll and income taxes but requiring no payments to hospitals or doctors by patients, the Kennedy-Corman bill, despite its higher cost, would impose virtually the same total cost for health care on families earning under $15,000 as the Administration and Kennedy-Mills bills, the report said.

But to raise the extra $23 billion it would cost, the Kennedy-Corman bill would impose sharply increased taxes on upper income families—as much as $1,000 a year more than under the Administration and Kennedy-Mills bills for a $40,000-a-year family.

ONE OF THE NATION'S MOST POWERFUL UNIONS—the Teamsters—backed away from support for the Kennedy-Corman bill to federalize national health care.

A high Teamsters official told a national health conference that "we have become increasingly distressed . . . by the possibility that a National Health Insurance plan which runs all of the money for the purchase of health care through the federal government, such as the Health Security Act (Kennedy-Corman), might be adopted . . . we cannot support a program that gives the federal government total control over financing and delivery of health care."

Speaking before the National Leadership Conference on America's Health Policy in Washington, D.C., Daniel Shannon, Teamsters executive director of the Central States, Southeast and Southwest Areas, Health, Welfare and Pension Fund said "let's maximize the utilization of the private system rather than handing the entire problem over to the government."

Hitherto, organized labor had presented what appeared to be a united block in favor of the Kennedy bill, which would eliminate private health insurance and have the government finance all health care. The Teamsters had not been in the forefront of the labor push, but they had not opposed it.

THE SENATE HAS PASSED LEGISLATION establishing a Presidential Commission to review all biomedical and behavioral research done by the government.

The Presidential Commission would replace an existing commission now working in the Department of Health, Education, and Welfare. It would consist of 11 members from the

Continued

fields of law, ethics, theology, the sciences and health administration. Sponsors of the legislation want the Commission to have broad authority over all federal departments and agencies. A special section of the bill, now before the House, directs the Commission to investigate research in DNA.

THE FINANCIAL OUTLOOK FOR SOCIAL SECURITY remains precarious, the Trustees of the system have reported to Congress. They predict Social Security will be running in the red for many years unless Congress moves swiftly to increase the tax.

The economic upturn over the past year has helped the short-range outlook somewhat since the last annual report to Congress, but over the long-haul Social Security appears to be in worse trouble than ever.

The actuarial shakiness of the Social Security system and public and Congressional resistance to increasing the Social Security tax bite have severely damaged prospects for sweeping National Health Insurance proposals based on Social Security financing.

The trust funds for Old Age and Disability Benefits will decline by $4.3 billion this year, instead of the $5.8 billion predicted in a 1975 report.

"The long-term picture is now shown, under new assumptions, as holding out the prospects of higher future costs than had been previously projected." Social Security Commissioner James B. Cardwell said.

Cardwell is secretary of the Board of Trustees which includes Treasury Secretary William Simon, HEW Secretary David Mathews and Labor Secretary W. J. Usery.

The report covers the four trust funds established for Social Security programs, including the Old Age and Survivors trust funds, disability insurance, and Medicare hospital and supplemental insurance.

PRESIDENT FORD HAS TOLD CONGRESS that deaths from coronary heart disease, stroke and hypertension continue to decline. The third annual report of the National Heart and Lung Institute which Ford sent to Congress said that the new initiatives undertaken since 1972 provide "encouraging programs in the fight against heart, blood vessel, lung and blood diseases." "These diseases, in 1972, led to an estimated national economic loss of more than $57 billion annually," Ford said. ◄

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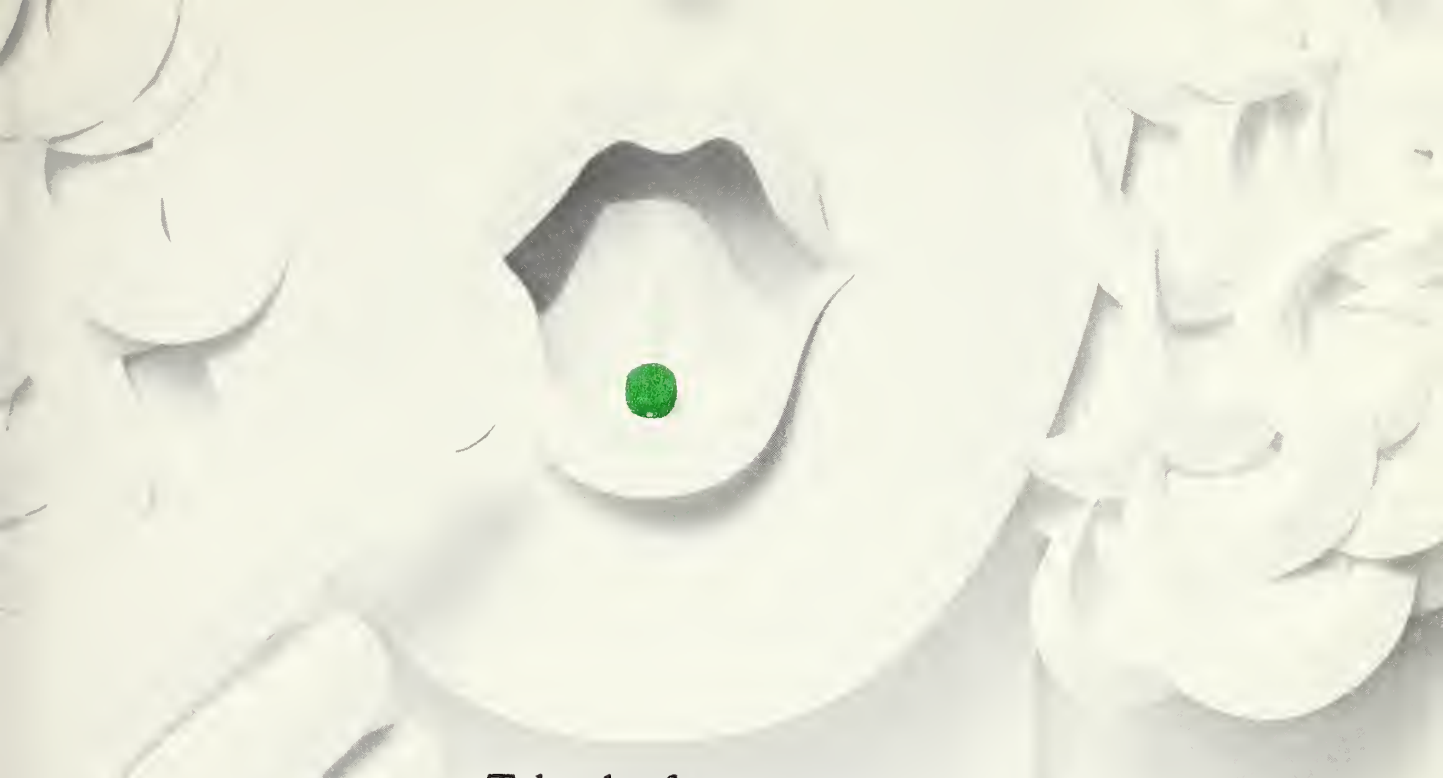
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1. Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976.

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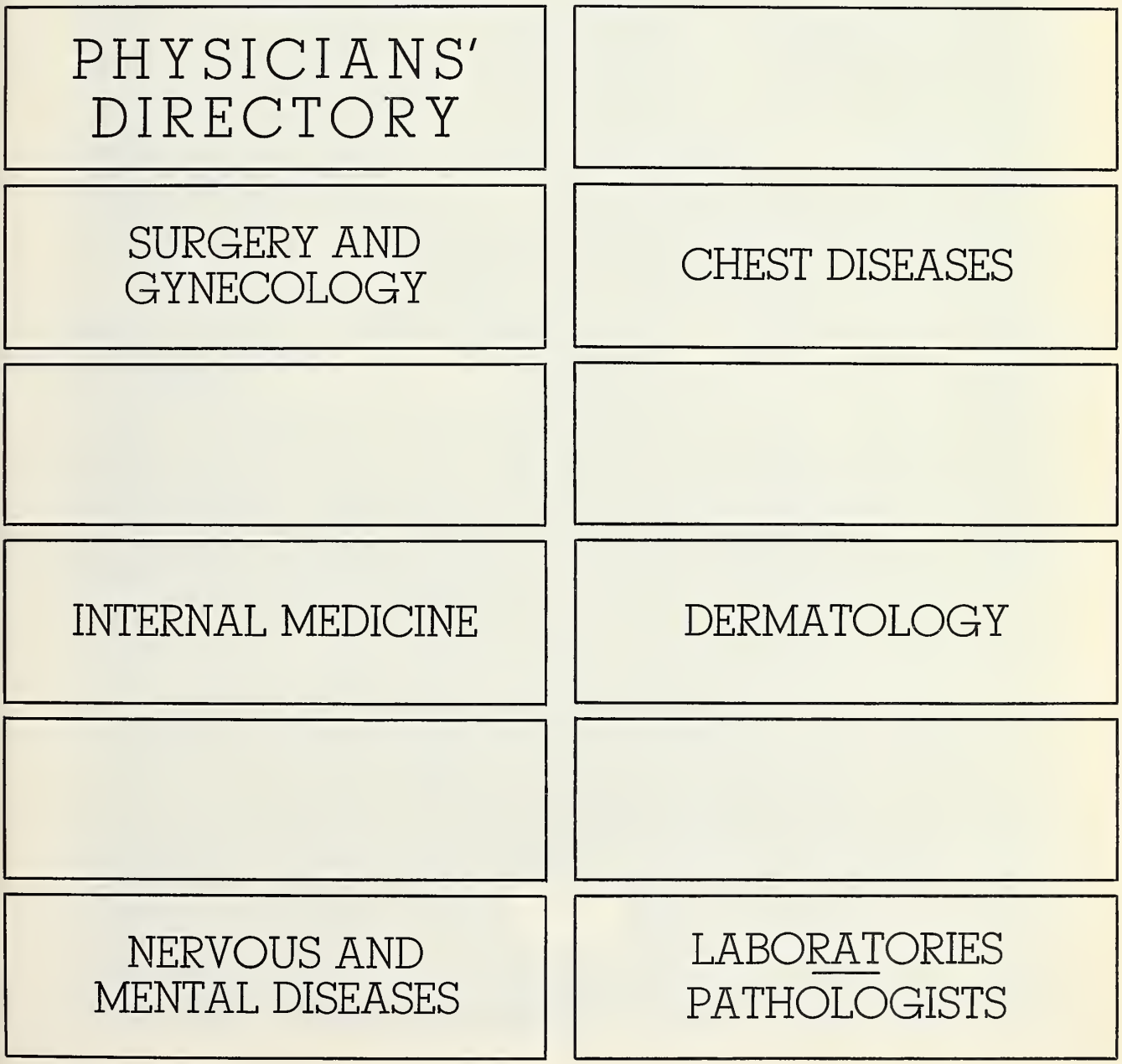
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Report of Radiation Therapy and Therapeutic Radioisotope Facilities and Personnel in Indiana

A Model for Projecting Need in 1980

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Abstract

This report gives the conclusions of a study by a committee to assess the present facilities and manpower in radiation therapy in the state of Indiana and to project the needs for 1980.

Guidelines were developed for standards for radiation therapy services and defining three categories: Clinical Cancer Center—at major hospitals serving the greatest number of patients; Affiliated Units—treating, for the most part, skin cancers, and palliative cases; and Education-Research Centers—teaching and training centers for radiation therapy personnel which also are tertiary care centers. It was assumed the quality of care at all centers would be optimal for the patient, and the designation implies only the capacity for treatment.

The standards established by the committee may be used by physicians, hospitals and the State Board of Health in evaluating and determining the future need for equipment and staff.

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I. Introduction

ON Jan. 4, 1975, President Ford signed the National Health Planning Resources Development Act of 1974, Public Law 93-641, which amended the Public Health Service Act. Within 18 months of the enactment date, the Secretary of Health, Education and Welfare is to issue guidelines concerning the national health planning policy which will include "standards respecting the appropriate supply, distribution and organization of health resources." One of the priorities of these guidelines will be the development of a multi-institutional system for coordination or consolidation of institutional health services, including radiation therapy.

Under the new law a "state medical facility plan" is required. This plan must be based on a statewide inventory of existing medical services and the need for additional medical services, equipment and facilities.

The Indiana State Board of Health was designated by the Governor as the State Designated Planning Agency in January 1973 under the provisions of Section 1122, Social Security Act. In that capacity, the State Board of Health has a responsibility to determine whether proposed capital expenditure projects which: 1) exceed $100,000, 2) change bed capacity, or 3) substantially change the service of a health care facility or health maintenance organization, should be approved.

To meet the requirements of these laws and to develop guidelines for greater efficiency of resource allocation and more effective delivery of health and medical care in Indiana as it applies to radiation therapy services, Dr. David J. Edwards, director, Health Facilities, Services and Resources Development, Indiana State Board of Health, recommended the formation of a committee to: 1) study the radiation therapy services available in the state of Indiana, 2) make recommendations for setting mini-

mum standards for these services, and 3) project the future need for radiation therapy services in Indiana.

Under an Indiana Regional Medical Program grant, a technical advisory committee of eight members was established. This committee consists of the following members:

Five Indiana physicians, representing all geographical areas of the state, with basic knowledge in the field of radiation oncology.

An executive director of an area-wide Comprehensive Health Planning Agency (B Agency).

An administrator from a hospital which is currently providing radiation therapy services.

A nationally recognized authority on health care delivery and planning as it relates to radiation therapy services.

A criticism leveled at the makeup of this committee might be a lack of "consumers," however, it should be pointed out that the function of this committee is not to eliminate any existing health facilities or approve any new radiation therapy facilities but to provide the necessary guidelines and technical information only for future health planning organizations as to criteria to be considered in order to provide the citizens of Indiana with the best possible radiation therapy services at the least possible cost. It is assumed that all those future health planning agencies in a position to approve new health care facilities in this area will have adequate consumer representation.

With the unrestrained proliferation of radiation equipment within hospitals and private offices in the state, an obvious discrepancy has developed between the amount and distribution of these units and the availability of trained personnel to operate the equipment. It is axiomatic that inefficient utilization and unnecessary duplication of health services bring unproductive increases in cost of health care.

To develop guidelines for ideal radiation therapy units in Indiana, several sources of information were distributed and reviewed by the committee members. The list of publications reviewed prior to the development of the Indiana plan is listed under "references." Among the reports most applicable to Indiana were those developed by the New Jersey Regional Medical Program,[1] the Wisconsin Regional Medical Program,[2] and the Tri-State Area Health Planning Council.[3] The report from Wisconsin "Standards and Guidelines for a Radiation Therapy Network in Wisconsin" was particularly helpful and was used rather extensively to develop the guidelines as they would apply to Indiana. The committee thought this report was an excellent example of the direction and depth of studies needed for effective planning in the delivery of quality medical care.

II. Standards for Radiation Oncology Units

A. Types of Units

Three principal groups of radiology oncology practices can be identified from the several different types of units which currently exist in hospitals and offices in Indiana. These groups are defined as follows:

1. Clinical Cancer Center (CC) —A major treatment unit whose primary function is patient care and can be considered as a self-contained cancer treatment center capable of handling the majority of patients requiring sophisticated radiation therapy services. These units contain modern radiation therapy equipment, are staffed with full-time radiation oncologists and specialty physicians required to provide a multidisciplinary approach to the treatment of patients with cancer. A sufficient patient load and population base would be required for efficient utilization of these facilities.

2. Affiliated Unit (AU) — The primary function is patient care in the form of palliation or simplified treatment procedures using existing x-ray equipment. In this unit neither the patient load nor the population base could support the expensive sophisticated equipment, personnel or support services required to provide necessary radiation therapy treatments which are required for the majority of cancer patients.

3. Education Research Center (ERC)—The primary function is education and research. This unit is not competitive with the AU or CC units but complements them. Patient care is mainly for selected patients, using innovative technics or specialized equipment that is ordinarily not available in the Clinical Cancer Centers. Sufficient patient population and case load are required to fulfill the primary mission, which is education, training and research.

The Clinical Cancer Center is usually located in a large community hospital and represents the most efficient utilization of resources, utilizing optimal skills and technology in radiation oncology. These centers will normally treat more than 300 new cancer patients per year, excluding skin cancer, and have the trained personnel and necessary facilities for the diagnosis and treatment of cancer of most anatomical sites.

The Affiliated Units are generally in a state of change, and interest in radiation oncology varies from unit to unit, depending upon the support and interest of the hospital administration and medical staff. The Affiliated Unit normally has fewer than 300 new cancer patients per year and is usually located in the smaller community hospitals providing general health care. The committee thought that these Affiliated Units were unprofitable for the hospital and should be approaching status as Clinical Centers or making arrangements to phase out their radiation therapy services. With a low volume of new and old cancer patients, only part-time work in radiation oncology would be required, and the facility would not be able to afford the current spec-

trum of sophisticated equipment required to treat a large variety of cancer patients. The AU, therefore, will look toward the CC or ERC units for consultation and patient referral for the majority of patient treatments.

An Educational Research Center has its primary mission in education and training in both basic and clinical cancer research. The differentiation of these two radiation oncology units (ERC and CC) does not imply different levels of patient care. Care received by any patient in any given unit must represent optimal care of that patient. Every cancer patient should, of course, have the benefit of consideration of all possible modalities of therapy through readily available consultation with cancer specialists currently on the medical staff. Provisions to share resources among the various units should be explored, particularly in the urban areas.

B. Concepts in Setting Standards

1. Patient Load: The minimum of 300 new cancer patients for the Clinical Cancer Center was used as an approximate number of patients required to make the center economically self-sufficient. One might argue that in some of the smaller hospitals this figure could never be met; nevertheless, a need would exist for radiotherapeutic services. This figure should be flexible, depending upon the location of the hospital and availability of services in the geographic area. If the new cancer patient load is significantly lower than this figure, however, a properly staffed and equipped department of therapeutic radiology would represent a serious financial drain on the other hospital services.

2. Personal Resources: It was difficult for the committee to justify the duplication of expensive and sophisticated equipment and the highly trained specialists required to operate this equipment merely for the convenience of either the patient or the referring physician. Most referring physicians who have a clear understanding of the tremendous outlays of money required for modern radiotherapeutic services readily accept the concept of referral to the larger Clinical Center for specialized care.

With the rapid growth of knowledge in medicine and the resulting diversification of specialties in radiology into diagnostic radiology, with many subspecialties of neuroradiology, pediatric radiology, etc., therapeutic radiology with subspecialties in specific disease areas, and the increasing use of isotopes and technics in nuclear medicine, it is almost impossible for a "general radiologist" to keep sufficiently abreast of these rapidly developing fields in radiology. It is for this reason the term "radiation oncologist" is used, denoting a physician who has had recent specialized training or has considerable interest and experience in the use of radiation therapy in a wide range of cancer patients. The term is used not to exclude highly motivated "general radiologists" from practicing a high degree of skill in radiation therapy, but to place proper emphasis on the kind of specialized radiologist required in the future to maintain expertise in this highly specialized field.

3. Equipment: In defining the type of equipment required for each unit the committee deviated from previously used definitions of supervoltage and megavoltage units and identified megavoltage units as those with energy ranges of 12 MeV or greater, since it is only in this energy range and above that a practical electron beam that is required in modern clinical radiation therapy practice settings can be produced. It should also be noted that Affiliated Units, with few patients undergoing treatment, for the most part have the lower voltage equipment—i.e., superficial and orthovoltage units. These units are satisfactory for superficial lesions (skin cancers) and many palliative treatments of advanced cancer patients, but any curative treatments for cancer patients should be performed in the Clinical Center where necessary equipment and personnel are available for optimal patient treatment.

4. Supporting Clinical Facilities: "Supporting clinical facilities" was a difficult area to evaluate, because there was a wide diversity of opinion, not only among the committee members but also among practicing radiation oncologists throughout the country, as to which supporting equipment should be located in the department and which items could be economically shared with other departments in the hospital. It is in this area that the most rapid advancements in therapeutic radiology are being made. Tumor localization equipment (EMI scanner, computerized isodose curves, treatment simulator, etc.) presents perplexing problems for the practicing therapist in the Clinical Center, because the expenditure for this expensive support equipment must be weighed against improved patient care. It is for this reason that the committee was hesitant about making specific recommendations. In the future, with increased experience and clinical research information received from the Education Research Centers, it is hoped that the required support equipment question will clear.

5. Registry and Cancer Committee: It was the unanimous opinion of the committee that a tumor registry conducting patient follow-up and a coordinated cancer committee (tumor board) are required in all three units. Their importance in the CC and ERC units is obvious, and it was thought that, in order for an AU to obtain CC status or to phase out its activities in radiation therapy, the hospital administration and practicing physicians in the

hospital should have accurate and reliable information upon which to base their decisions. In addition, the multidisciplinary cancer committee gives valuable service to physicians by providing consultation services, cancer education, quality care assurance and documentation of cancer treatment problems in the hospital.

TABLE I

Multidisciplinary Cancer Committee

Primary Care Physician
Radiation Oncologist
Medical Oncologist
Surgical Oncologist or Surgeon with special interest in Oncology
Diagnostic Radiologist
Pathologist
Internist, Pediatrician or Gynecologist with special interest in Oncology
Tumor Registrar or Medical Records Representative

Table I lists the recommended membership of the hospital cancer committee. This committee membership will vary, especially at the AU level, depending upon the various specialties represented on the hospital staff.

Table II identifies the minimum recommended standards for Indiana

TABLE II

INDIANA RADIATION ONCOLOGY UNITS—RECOMMENDED MINIMUM STANDARDS

	CLINICAL CENTER	AFFILIATED UNIT	EDUCATION-RESEARCH CENTER
A. Patient Load	Minimum of 300 new cancer patients per year (exclusive of skin cancer)	Fewer than 300 new patients per year	New cancer patient minimums to meet AMA free-standing residency program requirements
B. Personnel			
Radiation Oncologists	1 per 300 new cancer patients per year, Board Certified or Board Eligible	Board Certified or Board Eligible	1 per 200 new cancer patients per year
Radiation Physicists	1 per 300 new cancer patients per year, Master's Degree plus American Board of Radiology certified or equivalent-experienced	Affiliation agreement with CC or ERC	1 per 300 new cancer patients per year, Master's Degree plus American Board of Radiology certified or equivalent-experienced
Radiobiologist	May be justified	Not justified	1 per 600 new cancer patients per year, Master's Degree in Radiobiology
Residents and Training Fellows	Residency training program affiliated with ERC's	No residency training	1 per 150 new cancer patients per year, Free standing residency program approved by the A.M.A.
Radiation Therapy Technicians	2 per supervoltage or megavoltage radiation units, registration by American Registry of Radialagical Technologists	1 per superficial or orthovoltage radiation source, registration by American Registry of Radiological Technologists	2 per supervoltage or megavoltage source, registration by American Registry of Radiological Technologists
	2 per simulator unit 1 per superficial or orthovoltage source		2 per simulator unit 1 per superficial or orthovoltage source
Nurses	1 per 400 new cancer patients per year—R.N. or L.P.N.	May be shared with other departments	1 per 400 new cancer patients per year—R.N. or L.P.N.
Dosimetrists	1 per 600 new cancer patients per year	None required	1 per 600 new cancer patients per year
Other Members of the Treatment Planning Team: Development Engineers, Mould-room Technicians, Electronic Technicians, Simulation Technicians, Machinists	Available to department, use as needed	Consultation with CC or ERC	Available to department, use as needed
Other Personnel: Photographer, Statistician, Computer Programmer, Medical Social Warker, Radium Curator, Transportation Coordinator, Aides for Movement, Orderly, Record Clerks, Secretary, Administrative Assistant, Transcriber	Available to department, use as needed	Available to department, use as needed	Available to department, use as needed
C. Source of Radiation			
Superficial (up to 150,000 volts)	I	I	I
Orthovaltage (between 150,000 & 1 M. volts)	I	I	I

Supervoltage (between 1 and 11.9 millian volts including Cabalt-60)	At least ane unit required and a secand added when utilization af the first exceeds 83%	Not required	At least ane unit required and a secand added when utilizatian af the first exceeds 83%
Megavaltage (between 12 and 25 millian volts including machines capable af effective electran beam therapy)	At least ane unit is required in the 12-25 meV range. It must have electran beam capabilities. When patient laad exceeds 83% utilizatian, a secand machine may be required.	Nat required	At least ane unit is required in the 12-25 meV range. It must have electron beam capabilities. When patient laad exceeds 83% utilizatian, a secand machine may be required.
Radium + Radium equivalent Cesium or gamma emitting	200 mg plus available in haspital isotapes	Radium may be rented	200 mg plus available in haspital
D. Supparting Clinical Facilities			
Treatment Planning Simulatar	Optianal—if third radiation high energy machine is available, a secand simulatar may be justified.	Not required	Optianal—if third radiatian high energy machine is available, a secand simulatar may be justified.
Autamatic Isadose Camputer	May be shared with ERC	Nat required	Strangly recammended
Tumor Lacalizatian Equipment, Ultrasaund Unit, EMI Scanner, etc.	Open ta justificatian	Nat required	Open ta justificatian
E. Other Suppart Facilities and Services			
Dressing raams and ready waiting raams	A minimum af ane per treatment raam (Twa are recammended)	At least one per treatment roam	A minimum af one per treatment raam (Two are recammended)
Fallow-up Facilities	Shared with ather ancalagy services or may be part of radiatian therapy unit	Shared ar caaperative arrangements with local haspital	Strongly recammended in department, may be shared with ather ancology services
Tumar Registry	Required	Required, may be shared with CC or ERC	Required
Cancer Cammittee (Tumar Boards)	Required	Required	Required
Radialagical Physics Lab	Recammended in department, may be shared with ather departments	Nat required	Required in department
Machine and Electranics Shop	Recammended in department, may be shared with other departments	Nat required	Required in department
Bed Requirements	2.5 per 100 new radiatian therapy cases per year	2.5 per 100 new radiatian therapy cases per year	2.5 per 100 new radiation therapy cases per year
Records	As recammended by AMA Residency Pragram Standards in Therapeutic Radialagy	As recommended by AMA Residency Pragram Standards in Therapeutic Radialagy	As recammended by AMA Residency Program Standards in Therapeutic Radialagy
Distribution af Facilities	1½ hour ane-way cammuting time far megavoltage facilities 1 haur ane-way cammuting time for supervoltage facilities	Nat relevant	Nat relevant, primary goal is educatian and research

radiation oncology units as to patient load, required personnel, sources of radiation and supporting clinical facilities.

III. Current Indiana Radiation Inventory

All hospitals in the state were sent a simplified screening questionnaire requesting information as to whether their hospital provided radiation therapy services for patients. A response was received from 126 hospitals, which represented all major hospitals in the state of Indiana, and, of these, 42 indicated they offer radiation therapy services. These 42 hospitals were then sent a more extensive, detailed questionnaire requesting pertinent information concerning number of radiation therapists doing full-time therapy, number of new cancer patients seen yearly, number of yearly follow-up visits, radiation equipment available in the department, plans for purchase of future equipment and plans for expansion of radiation therapy department, utilization of present equipment, etc.

Because of a lack of common terminology regarding new patients, visits and treatments, a few hospitals had some difficulty in responding to the questionnaire. For the most part, the information received appeared to be a realistic evaluation of the current status of radiation therapy units in the state. Detailed results of this survey are available from the Indiana State Board of Health and will be published sometime in 1976.

Based upon the results of this questionnaire, Table III summarizes the units in the state by region (see Figure 1, map of regions). Using the criteria established by the committee for minimum number of new cancer patients and existing equipment and personnel, there are six Clinical Centers, thirty-three Affiliated Centers, and one Educational Research Center. Several Affiliated Units are close to approaching Clinical Center status as defined previously. It is emphasized that the designation of a unit as an Affiliated Unit in no way should be interpreted as an indication of the quality of care rendered to patients but only as an indication of the number of new cancer patients treated and kind of therapeutic equipment available in the hospital.

This radiation therapy inventory describes existing equipment and radiation therapy services and may be useful in providing information to hospital administrators and hospital staff physicians as to how their current facilities compare with other hospitals in their own region and may serve as a guideline for future planning and development of radiation therapy services. The only areas that lack complete radiation therapy services are Regions 12 and 14 (Madison and New Albany) which are served by several excellent radiation therapy facilities in Cincinnati, Ohio, and Louisville, Kentucky. (See Figures 2 and 3.)

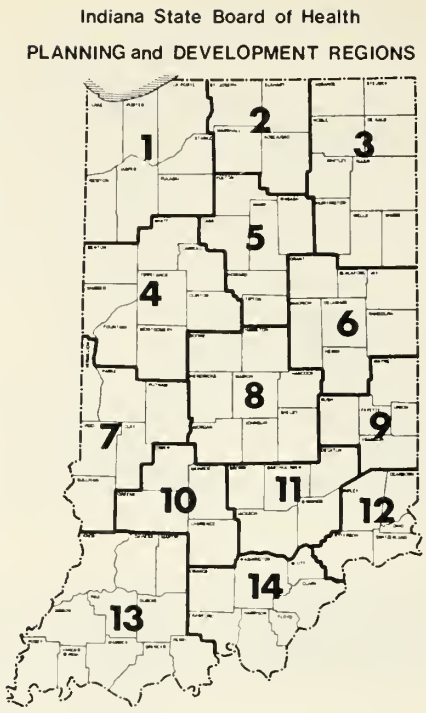


FIGURE 1

IV. 1980 Radiation Therapy Planning Inventory

Despite the inherent problems in attempting to forecast the future, the committee was required to make a reasonable attempt to predict needs for radiation therapy in 1980. Certain planning assumptions had to be made based upon population growth, estimated number of cancer patients, use of radiation therapy services, etc.

The following assumptions were used, and it should be pointed out that they do not always reflect a unanimity of opinion, nor can they be construed as an infallible guide in this rapidly changing field.

A. Basic Assumptions

1. Three hundred persons in each 100,000 population will develop cancer (exclusive of superficial skin cancer and carcinoma-in-situ of the uterine cervix) during any one year. Cancer registries in Western Canada place the cancer incidence rate there at 330 per 100,000 population base. The American Cancer Society[4] uses the figure of 280 per 100,000 for the United States.

2. A total of 430 persons in each 100,000 population will be under medical care during the year for cancer (excluding superficial skin cancer and carcinoma-in-situ of the uterine cervix).[4]

3. One hundred fifty persons in each 100,000 population will die from cancer during the year.[4]

4. Ninety-three persons in each 100,000 population will be cured of cancer (excluding superficial skin cancer and carcinoma-in-situ of the uterine cervix) during the year.[4]

TABLE III — 1974 STATISTICS

Regian	Majar City	Fulltime Radiatian Oncalagist	Na. af Hasp. Offering Rad. Ther. Services	Clinical Centers	Affiliated Units	Superficial	Ortha	Supervalt	Megavolt	New Rad. Therapy Patients in Region
I	Gary	2	5	1	4	1	5	3	0	1,146
II	Sauth Bend	2	3	1	2	0	3	2	0	570
III	Fart Wayne	2	4	1	3	0	4	4	0	1,081
IV	Lafayette	2	2	1	1	1	2	0	1	475
V	Kakama	0	4*	0	2	2	4	1	0	240
VI	Muncie	0	3	0	3	1	2	1	0	355
VII	Terre Haute	0	3	0	3	0	3	1	0	368
VIII	Indianapolis	6	7**	1	5	3	6	7	2	2,992
XI	Richmand	0	2	0	2	2	2	1	0	96
X	Bloomingtan	0	1	0	1	0	0	1	0	182
XI	Calumbus	0	2	0	2	1	1	1	0	101
XII	Madisan	0	1	0	1	1	0	0	0	30
XIII	Evansville	3	5	1	4	3	5	4	0	790
XIV	New Albany	0	0***	0	0	0	0	0	0	0
TOTALS		17	42	6	33	15	37	26	3	8,426

* 2 hospitals in this region have arthovolt equipment but are phasing aut radiation therapy services
** Includes an ERC unit at Indiana University Schaal of Medicine
*** Regian XIV is cavered by Lauisville, Ky., hospitals and partially by Regian XIII Evansville hospitals

5. Radiation therapy alone or in a combination of modalities will be utilized by a minimum of 50% of the new cancer patients during the year.[3]

6. A maximum of 43% of all new patients will return for a second course of radiation therapy for the same cancer site. The committee assumes an incidence rate of 300 people per 100,000 population contracting cancer, while the American Cancer Society[4] shows 430 per 100,000 with cancer who are currently under care. Both rates are exclusive of superficial skin cancer and carcinoma-in-situ of the uterine cervix. This gives a ratio of old, or returning, patients to new patients of 130 divided by 300, or 0.43. Added to the new patients, 1.00, this yields a total of 1.43 fraction of all old patients to new patients. It is realized that 0.43 is the maximum in this factor, since radiation therapy courses cannot be given repeatedly in the same area, nor can they be given for an infinite number of treatments. The number of people who are under care and who have had one treatment course has reduced the probability of having a second or third treatment course for the same cancer site. It is clear that the value cannot exceed 1.43 and should be considerably lower than this.

7. Of all beginning patients in radiation therapy, 60% will be treated with curative intent and 40% with palliative intent.[5]

8. Of all returning patients in radiation therapy, 26% will be treated with curative intent and 74% with palliative intent.[5]

9. The average number of curative treatments on new patients is 24.[5]

10. The average number of curative treatments on a returning patient is 16.[5]

11. The average number of palliative treatments on all patients is 12.[5]

12. It is estimated that 5% of all cancer patients do not receive

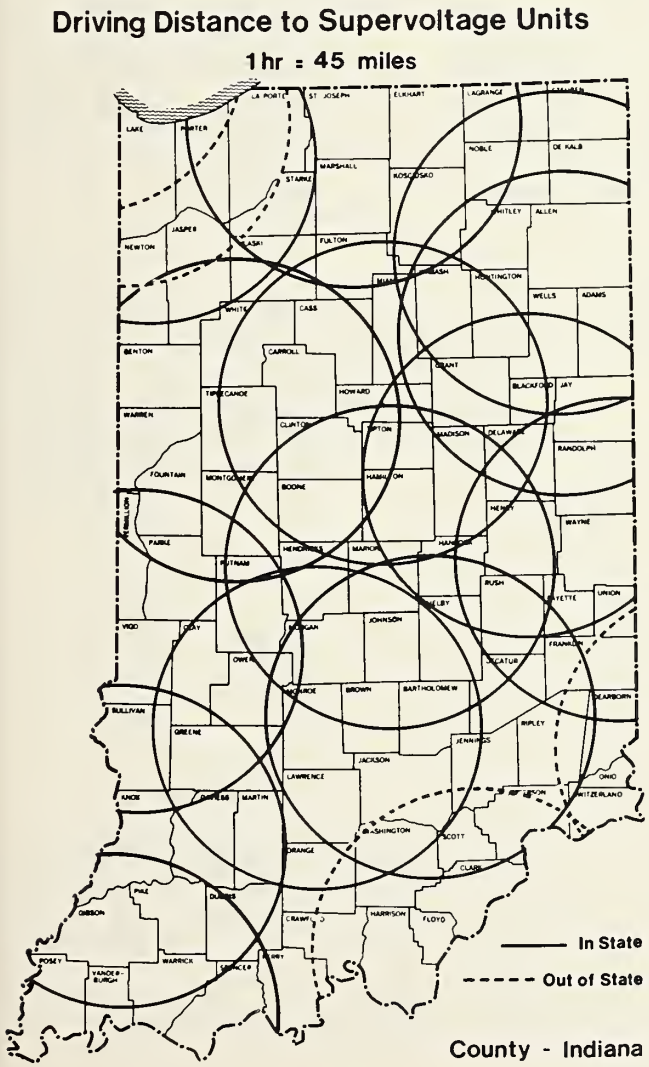


FIGURE 2

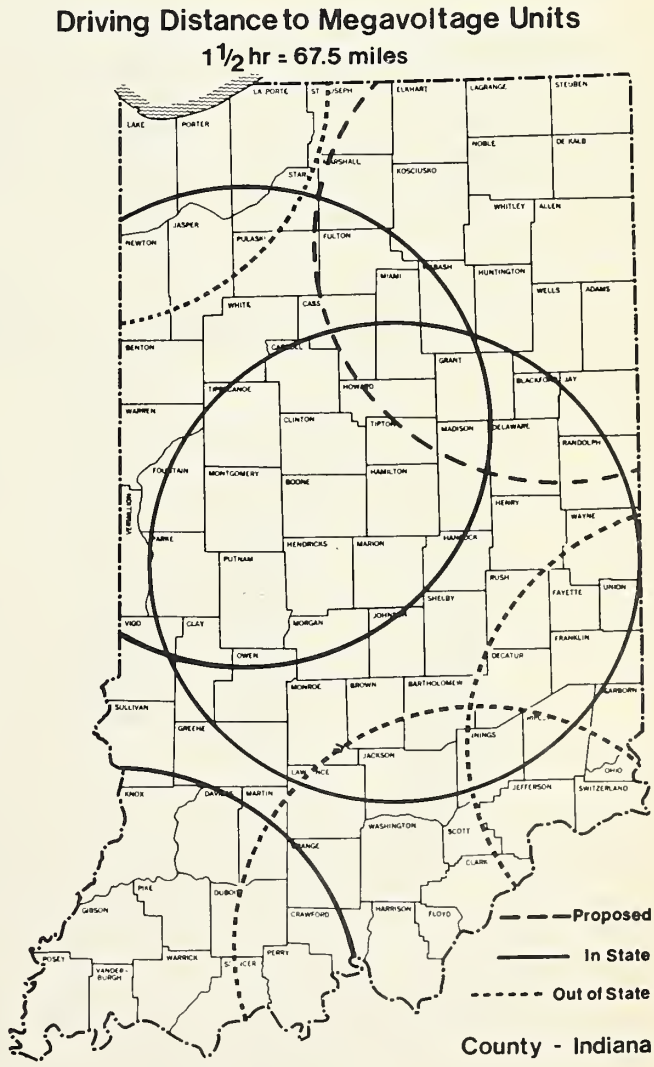


FIGURE 3

necessary treatment in their area; this includes those patients that are treated outside of their area.[5]

13. Ten percent (10%) of all radiation therapy patients (exclusive of superficial skin cancer) could be treated on orthovoltage equipment. It is recognized that a certain segment of cancer patients requiring radiation therapy who could be treated on orthovoltage equipment are currently being treated on supervoltage or megavoltage equipment. For better utilization of equipment, this segment (10%) could be treated on orthovoltage equipment.[5]

14. For utilization planning, a day is considered to be eight hours, with 250 workdays in a year. (Committee action)

15. Orthovoltage equipment can, with efficient management, give 30 treatments per day. (Committee action)

16. A cobalt-60 teletherapy unit can, with efficient management, give 30 treaments per day. (Committee action)

17. A supervoltage linear accelerator can, with efficient management, give 40 treatments per day.[5] (Committee action)

18. A megavoltage linear accelerator can, with efficient management, give 30 treatments per day. (The addition of the electron beam capability in megavoltage linear accelerators can actually decrease the number of treatments given per day because of the additional time required to change the equipment from one beam to the other.) (Committee action)

19. A Betatron can, with efficient management, give 25 treatments per day. (Committee action)

20. A utilization rate of 83% of the treatment capability of each supervoltage or megavoltage source constitutes efficient utilization. A certain amount of time for each supervoltage or megavoltage source must be considered for maintenance, weather delays for patients, and other reasons. Seventeen percent of the expected treatment capability per supervoltage or megavoltage source has been allowed for these non-utilization reasons. (Committee action)

B. Mathematical Model

In October 1974 a New Jersey report refined a mathematical model developed by Computer-Med Corporation for the Alabama Regional Medical Program "A Study of Regional Radiation Dosimetry System" dated February 1971. This formula has been modified to meet the Indiana planning assumptions.[5] Where:

I — crude cancer incidence rate
P — population
B — fraction of cases lost to necessary treatment, and those treated out of the area
F — fraction of cancer patients receiving radiation therapy
R — fraction of all patients to new patients

TABLE IV
PROJECTED PERSONNEL AND EQUIPMENT NEEDS FOR 1980 BY REGION

Region	Major City	Projected Total No. of Rxments Required in 1980	Capability of Existing Supervoltage Units in Area at 83% Efficiency	Supervoltage Current Utilization	Additional Radiation Oncologist Needed in Region by 1980	Additional Supervoltage Units Required to Meet Needs of 1980	Additional Megavoltage Units Required to Meet Needs of 1980
I	Gary	32,274	26,975	91%	2-3	0-1 (a)	0-1 (a)
II	South	18,504	14,525	67%	1	0-1	0-1
III	Fort Wayne	20,250	39,425 (b)	77%	1	0	0
IV	Lafayette	10,458	6,225	100%	—	1	0
V	Kokoma	9,234	6,225	29%	0 (c)	0-1	0
VI	Muncie	20,250	6,225	90%	2-3 (d)	2-3 (d)	0
VII	Terre Haute	8,334	6,225	49%	1	0-1 (e)	0
VIII	Indianapolis	47,520	57,788	64%	0-1	0	0
IX	Richmond (f)	5,742	6,225	18%	0	0	0
X	Bloomingtan (g)	7,830	6,225	48%	1	0	0
XI	Columbus	5,940	6,225	23%	1	0	0
XII	Madison (h)	3,240	—	—	—	—	—
XIII	Evansville	28,620	13,125	80%	0	0	0
XIV	New Albany	3,042	—	—	—	—	—

(a) Region I is in close proximity to mojor treatment oreos in Chicogo ond Michigan region; may require no odditional units.
(b) The institution meeting the clinicol center standards in Region III recently received approvol for a supervoltage unit or megovoltoge unit.
(c) There ore no full-time radiation oncologists in the region and many patients ore referred for treatment in Regions VIII ond IV. In addition, there is a supervoltoge machine in a private radiology clinic which has the capability of fulfilling any deficiency in treotment capability.
(d) Region VI is in close proximity to Region III, which may nullify projected needs for this area.
(e) Region VII is overlapped by Regions IV and VIII, which will influence desires to add equipment.
(f) Region IX hos since added o full-time radiation oncologist to the area, which will increase efficiency of supervoltage unit.
(g) Region X is in close proximity to Region VIII, which could eosily cover any deficiency in this region.
(h) Region XII is well covered by treatment centers in Ohio and Kentucky.
(i) Region XIV is in close proximity to radiation treatment focilities in Kentucky.

M — number of radiation treatments per patient

Thus,

PI — total number of new cancer patients in an area with population

PI(1-B) — total number of new cancer patients presenting for medical treatment

PI(1-B)FR — total number of new cancer patients presenting for radiation therapy treatment

PI(1-B)FR — total number of new and old cancer patients possible for radiation therapy treatment

PI(1-B)FRM — total of radiation therapy treatments needed for a population in one year (both old and new patients)

Where:
I = 300/100,000, B = 0.05, F = 0.50, R = 1.43 and M = 18, we can arrive at a planning figure for each of the 14 regions. Table IV lists the projected personnel and equipment needs for 1980 by regions.

C. Calculation of Needs for 1980 Using Mathematical Model

1. Equipment Needs by 1980—Based upon the American Cancer Society incidence rate, 14,880 patients developed cancer in 1974 in Indiana. Assuming that all these new cases would be treated and 50% of all new cases would require radiation therapy, there would have been 7,440 new radiation therapy patients and 4,018 returning patients, for a total of 11,458 radiation therapy patients. In 1974 the hospitals reported 7,474 new radiation therapy patients and 1,069 returning patients, a total of 8,543. A 25.4% difference existed between the theoretical usage and the usage reported by the radiation therapy departments for the calendar year 1974. If the existing units were operated with *minimal* adherence to the standards, a capacity of 9,799 patients would have existed at the 83% efficiency level. A 13% *excess* capacity existed in 1974 over the actual radiation therapy service usage in Indiana. Based upon the planning assumptions, Indiana will have a projected need for 212,868 patient treatments in 1980. This would mean 8,270 new patients and 3,556 returning patients, or 11,826 radiation therapy patients would require therapy in 1980. With the present supervoltage and megavoltage teletherapy equipment, plus the equipment presently being installed and the approved additional facilities in Region 3 (Fort Wayne) and Region 8 (Indianapolis), the state will have the capability, at 83% efficiency, of 228,251 treatments or 12,631 patients yearly. This amounts to a 7.2% excess, if all projected radiation therapy patients were to be treated in a hospital. It also assumes that all treatments in radiation therapy will be given on supervoltage and megavoltage units, disregarding superficial and orthovoltage capabilities.

For this reason, no additional megavoltage facilities are recommended at this time.

2. Manpower Needs by 1980—The projected radiation therapy load for 1980 will require 27.57 full-time radiation oncologists. At the present time, 21 radiation therapists are practicing a full-time equivalency of 16.51 persons. If those physicians presently practicing radiation therapy carried a full load in therapy, Indiana would need 6.57 additional full-time radiation oncologists or 11.06 if no higher percentage of treatments is done by those radiation therapists presently practicing. These figures are based upon one radiation oncologist per 300 new radiation therapy patients.

One of the current problems is the shortage of the personnel needed to direct and give radiation therapy. There are not enough physicians, physicists, dosimetrists and technologists in this subspecialty to treat the number of patients who could be expected to benefit from therapy. Investments in additional equipment must be examined with great care to insure adequate caseloads *and* sensible growth on both a regional and statewide basis. Until the need for additional radiation production sources is demonstrated, a moratorium on new units is needed to achieve optimum economical care. The transition of already established Affiliated Units into Clinical Centers is strongly recommended to achieve maximum usage of equipment and personnel.

V. The Long-Term Future of Radiation Therapy Services in Indiana

Major advances in medicine in the past few decades have occurred when the skills of several disciplines have been focused on a specific problem. The control of cancer requires such broad consideration involving many disciplines and organizations. Physicians generally agree that the desirable approach to patient management must be multidisciplinary. The clinical management of cancer by a team approach involving full consultation between specialists in the services involved is already an accepted fact.

Specialists directly involved in the care of the patient with cancer are in agreement that the most crucial period for multidisciplinary management is at the time of the initial diagnosis and decisions on treatment.

With the initial diagnosis of cancer, all available skills should be brought to bear on that patient's problem to determine the extent of disease and the proper treatment to be implemented. Treatment should evolve following group discussion between physicians whose specialized training and experience in the cancer field permit them to choose the method or combination of methods most likely to provide the greatest chance of cure, or the best

palliation when cure is not possible.

Several states have established multidisciplinary cancer centers for the management of the patient with malignant disease.

The centralized cancer hospital concept has many advantages:

1. It encourages the recruitment of specialists and permits the development and full utilization of the costly and extensive facilities required for the investigation and treatment of malignant disease.
2. It allows specialists in cancer to gain a wide experience in the treatment of uncommon tumors. As a result, policies of investigation and treatment can be developed which will lead to better patient care.
3. It fosters appreciation by all specialists of the value of each treatment modality, thereby facilitating the development of coordinated programs of investigation and treatment.
4. It encourages the professional staff to keep abreast of recent developments, fosters a critical appraisal of current therapy, and stimulates efforts to improve patient care.
5. It provides an excellent source of information to practicing physicians on the latest methods of diagnosis and treatment of malignant disease.

Acknowledgement

We gratefully acknowledge support by the Indiana Regional Medical Program for a study by the Radiation Therapy and Therapeutic Radioisotope Subcommittee of the Technical Advisory Committee for Seven Specialized Medical Services. This report is based on the conclusions of this Subcommittee.

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From the **Transactions of the Indiana State Medical Society**

100 Years Ago

It will doubtless be remembered by members of this association who took interest in the question, when the subject of Puerperal Eclampsia was under discussion, at its last session, I expressed by apprehension that the tendency of the period was to ignore bleeding in its treatment, as in those of many other forms of disease of perhaps equally well established congestive nature. A rather severe criticism of views then crudely and hastily expressed, has induced me to make a more thorough investigation of the subject in order that I might, if possible, confirm my conviction of the dangers of dispensing with an agent, in which in a long life of successful practice I have placed my chief reliance; and now feel that the occasion should not be lost to record my protest, in an appropriate manner, against the exclusive substitution of any remedy for blood letting in a disease of so well established congestive character as that of puerperal convulsions. . . .

But so convenient and so easy is the application of chloroform, and so promptly withal does it certainly, in most cases, arrest those external manifestations of the disease and relieves all apprehensions for the time being, that, it need not be the subject matter of wonder, especially in the growing prejudice against bleeding (engendered by conservative writers and teachers in our ranks, and encouraged by the hosts of outside empyrics), it should rapidly acquire the dangerous reputation of almost exclusive necessity and efficiency in the disease in question.

The design of my paper is to inquire into the merits of the various contending remedies respectively, and endeavor to prove by good authority that blood letting in eclampsia is not only **not** justly superceded by anaesthesia, but that at the present moment it is regarded, when judiciously practiced, as an indispensable agency in obviating and removing that otherwise fatal congestion which I claim as the cause of all severe cases of this formidable disease. . . . **"Treatment of Puerperal Eclampsia," G. W. Mears, M.D., Indianapolis, 1876.**

Medical Care During the Revolutionary War

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Nashville

THE beauty of the magnificent Hudson River Valley was nearly concealed from view by the swirling mists which hovered about it. Silently, five boatmen guided their small craft downstream, intent only upon the safe delivery of their cargo. The year was 1777, and their destination was Albany, N.Y.

Not far away, the citizens of Albany were gathered along the waterfront. They anxiously peered up the river, waiting for the first glimpse of the riverboats. Finally, the first one emerged through the mist and a messenger was immediately dispatched to fetch Dr. James Thatcher.

The cargo unloaded that October day was a precious one—young patriots who had been wounded while serving as soldiers of the Continental Army. Some of the men and women there undoubtedly felt remorseful as they assisted medical personnel from the nearby general hospital.

Not long before, these same young men had been among those who had marched through Albany on their way north to the Saratoga campaign. Their appearance had been a source of amusement for the Dutch burghers. Most of them were mere boys, with unkempt apparel and accoutrements unbefitting their mission. On being asked where they were going, the universal response was "Going to take Burgoyne."

The laughter occasioned by that remark must have seemed hollow to those who greeted the soldiers' return from the battlefields of Saratoga, 25 miles to the north. For, during September and October the American forces had met and soundly defeated the British troops commanded by General John Burgoyne. The youth ridiculed by the people of Albany were now returning as heroes, hideously wounded.

Ten days prior they had been lying wounded in the field where they fell. There was no formalized system of collecting wounded men during this period of our history, and many lay for hours where they fell without being evacuated. A man who had a comrade able to administer first aid at the time of the injury was lucky. No wounded could be evacuated until after the battle or, sometimes, even the following day.

At Saratoga, the battle of Freeman Farm, Sept. 19, 1777, continued well into the night, and engaging forces were too close to risk evacuation of the wounded. The screams and moans of the injured and dying went unheeded. It wasn't until the following morning, when the sounds of the injured's suffering could no longer be endured, that a gentleman's truce was effected so that the casualties could be removed from the field by makeshift litter, piggyback or any other feasible means.

Assisting in the evacuation of the wounded of the Continental Army were female "camp followers"—a factor about which we have learned little from the pages of history. In addition to the obvious moral support they supplied, these women made ammunition and carried it out to the soldiers on the field, often in the heat of battle. They prepared food, gave first aid and provided nursing care in the regimental hospitals. Residents of the towns and homes they passed along the route of troop movements were approached by the camp followers for donations of supplies, including cloth for bandages, which they made. These women generally were sweethearts and wives of the fighting men, and their contribution to the Colonies' eventual victory was invaluable.

One regimental hospital for the Saratoga campaign was located near the battlefield in a barn on the John Neilson farm just behind the farmhouse, which was used by American General Horatio Gates as headquarters. It was here they first brought the wounded, some of whom would later be ferried down the river to Albany.

The soldiers were made as comfortable as possible on straw, and what amounted to first aid was given them. Many had severe chest and abdominal wounds and would die within hours. A makeshift operating table was set up on which a surgeon could do minor surgical procedures and dressings to maintain the seriously wounded until they could receive more definitive care.

As soon as possible, those with major injuries were transported another mile by wagon (and for men who had fractures and sensitive wounds, this must have been a very painful experience) to the Hudson River. Here they were carefully placed aboard riverboats (a flat-bottomed type known as bateaux) to begin the daylong journey downstream.

Dr. Thatcher,[1] a young man

[1]Dr. James Thatcher was born in Barnstable, Mass., in 1754. He entered the

trained by the apprenticeship method, knew full well what to expect when he met the riverboats. He had walked with his regiment from Boston to his duty station at Ticonderoga, N.Y., in 1776 and had been treating the sick and wounded of the Northern Army since that time. Now he was stationed at Albany, where he was assigned from 20 to 24 patients at a time.

With the assistance of local citizens and medical personnel, Dr. Thatcher transported the injured men up the steep hill to the general hospital.

Originally built and used as a military hospital[2] during the French and Indian Wars, the two-story frame structure contained 40 wards which held approximately 12 men each. This building, which no longer stands, served as the principal hospital for the Saratoga campaign. Patients were bedded down on cloth ticks which were filled with fresh straw each time a new occupant arrived. Many would arrive with their wounds in a putrid condition and encrusted with blood and covered with maggots, as described by the physicians of that time.

Army hospitals of that period were allowed to hire one nurse for every 10 to 12 men. Such a nurse ordinarily was not specially trained, but merely a person willing to feed and take care of the basic needs of the soldiers. The nurse's first duty, upon the arrival of new patients, was to see that they were properly cleansed. Each patient was also assigned his own physician.

Dr. Thatcher personally examined all those under his care, first cleaning their wounds and killing any maggots with an application of tincture of myrrh. The chief and only major operations during this period were amputations, surgical incisions and drainage of wounds or abcesses, and trephining. The latter procedure consisted of burring a hole in the skull to relieve pressure or correct fractures.

In Colonial times a surgeon's skill was often equated with his speed in executing an amputation. Anesthesia was 70 years away, and surgical patients were commonly given a rum and opium mixture orally, then held down by two surgical mates. Dr. Thatcher was a surgeon of note who could amputate a leg at mid-thigh in 45 seconds. Stumps of extremities were bathed in hot oil to seal the large arteries and prevent a major hemorrhage.

The need for cleanliness and sterilization was just beginning to be recognized, and surgeons of this period considered the formation of pus to be a natural phenomenon of healing. It was considered a blessing for a wound to develop a generous amount of pus.

Most of the wounds Dr. Thatcher saw were caused by the musket ball, an approximately 3/4-inch shot fired from a musket. These muskets were effective probably no more than a hundred yards, but were amazingly destructive and accurate within that range. Injuries from the ax, tomahawk, bayonet or butt of a gun were less frequent; and even rarer were wounds resulting from cannonading, artillery and mortars of various types.

Dr. Thatcher was the principal medical historian of the Revolutionary War. He served with the Army from Bunker Hill to Yorktown and kept an interesting journal. His description of the Saratoga campaign included this observation: "If I turn from beholding mutilated bodies, mangled limbs, and bleeding incurable wounds, a spectacle no less revolting is presented, of miserable objects languishing under afflicting diseases."

Although the hospital at Albany primarily treated major injuries, Dr. Thatcher also saw many acute and chronic diseases of the time. Serious maladies in endemic or epidemic form were typhoid, yellow fever, pneumonia, measles, tuberculosis, dysentary, quinsy and venereal disease. Deficiency diseases, rickets and scurvy were seen and treated with proper nutrients.

Dr. Thatcher, as did other physicians of his time, relied heavily upon the use of herbs in treating diseases. Routine treatment consisted of emetics and laxatives, such as tartar emetic, rhubarb jallop, calomel and salts. Literally tons of Peruvian bark (this was also spoken of simply as bark) were used to relieve fevers. Its active alkaloid was quinine, later to be used as a specific medication for malaria.

Rums and wines were considered a panacea, and many physicians believed these prevented contagious diseases. On this basis, soldiers were given a ration of one-half gill of rum in bad weather, and sometimes large amounts when they were fatigued or on a long march. As a consequence, barrel fever (alcoholism) was added to the list of common diseases.

Another extremely popular, although debatable, form of treatment for a variety of diseases was phlebotomy, or blood-letting.

Mercurial inunctions were used for treating syphilis at that time and up into the 20th century. The soldier with a venereal disease was docked all pay while off duty. This practice persisted through World War II.

During the northern operation of 1777 there was a noted absence of two diseases which had marked almost every other campaign—i.e.,

Continental Army as a surgeon's mate early in 1775 and served at the Siege of Boston before going to Ticonderoga. In 1777 he became a mate in the general hospital, first at Ticonderoga and later, during the Burgoyne campaign, at Albany, where he remained until 1778. He subsequently was designated a surgeon and served with several different regiments before going to Yorktown in 1781. His journal was one of the most complete diaries of the war, but it deals more with military and general events than with medical subjects. After the war he settled at Plymouth, Mass., where he authored several books before his death in 1844, at the age of 91.

[2]Hospitals were established in existing structures (churches, dormitories, public buildings, etc.). Only one hospital was especially designed and erected for the soldiers of the Continental Army. Washington Hall, medical headquarters of the Valley Forge encampment, located at Yellow Springs, Chester County, Pa., was built for this purpose in 1778. It stood until 1902, when it was destroyed by fire.

smallpox and putrid fever or typhus. This was in sharp contrast to the year before, when no less than 50% of the troops in the Northern Army were ill at any given time, the worst record of the entire war. The average rate of illness overall was about 20%.

How desperate the situation was in 1776 is indicated by one report from Fort George in New York. An official tabulation showed the Army to have had 5,247 men fit for duty, with 3,917 sick in camp and 915 lighter cases sent away to convalesce. In a letter to a friend, John Adams wrote: "The smallpox is 10 times more terrible than the British, Canadians and Indians together."

Due to a major epidemic in 1776, the incidence of typhus was negligible in 1777.

The absence of smallpox was probably due to a vaccination program ordered by General George Washington. This program consisted of artificial transmission of live smallpox virus. For some time the use of live virus had been a custom in certain African tribes and was introduced into this country in the 1720s by Dr. Zabdiel Boylston. The smallpox thus induced was a milder form, and the mortality rate was extremely minimal compared to that of the natural disease. A safe vaccine, derived from cowpox, would have to await discovery by Dr. Edward Jenner at the turn of the 19th century.

Dr. Thatcher's supervisor, Dr. Jonathan Potts,[3] had been appointed Acting Medical Director of the Northern Army on Jan. 14, 1777, and sent to Albany to oversee the vaccination program. On Apr. 11, 1777, he was named Deputy Director General of Hospitals in the Northern Department.



A Continental Congress, shocked into action by the devastation wreaked upon the Northern Army in 1776 by typhus and smallpox, put Dr. Potts in this positon of authority. He asked for and was granted an unprecedented amount of money for medical supplies to prevent the recurrence of a high rate of mortality and morbidity.

As a result, the Saratoga campaign was medically financed better than any other campaign of the northern forces.

Both able and competent men, Dr. Potts and Dr. Thatcher were later given commendations by Congress for their humanity and great sense of duty.

It is interesting to note that the mortality rate among soldiers in the field was 2%. Of those who went to the hospital for any reason, 25% died. There is little doubt that the great hospitals of that day increased the death rate, and it is a severe indictment that many were the source of infection rather than a place for the effective treatment of it. The hospital at Albany, however, was a noticeable exception. This was due, in part, to the farsightedness of Dr. Potts, who early recognized that personal cleanliness was a prohibitive factor in the spreading of infectious diseases.

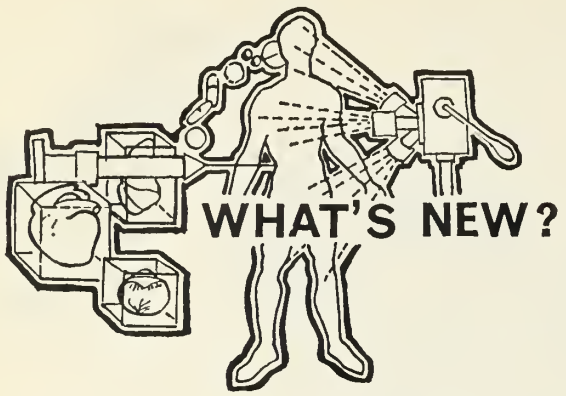
An estimated 80,000 died during the period of the Revolution. Approximately 8,000 of these were lost to combat-associated injuries; the others were lost as a result of complicating infections and diseases, both in the hospitals and in prison camps. Voltaire amply described the status of medical care thus: "The physicians pour drugs of which they know little for diseases of which they know less into human beings about whom they know nothing."

Physicians in Colonial America numbered approximately 3,500. Of this number, 1,400 answered the call to duty and served at one time or another during the period of the Revolution. Of all the patriots involved in and with the Continental Army, none were under a greater risk of mortality and morbidity than members of the medical profession. In most cases, medical personnel were not exposed to direct fire and relatively few of them were injured in that manner; but they were susceptible to the diseases they treated and, in many cases, willingly sacrificed their lives to aid their fellowmen.

It is extremely doubtful if, in any other war of this or any other nation, the medical men of the country played so important a part as they did in the American Revolution of 1775-83. ◄

Nashville 47448

[3]Dr. Jonathan Potts was born in 1745 at Pottstown, Pa. He studied medicine at Edinburgh, Scotland, but received his medical degree from Philadelphia College in 1771. He served his first wartime duty in 1776, when he was appointed a surgeon for American troops in Canada. Later that year he took charge of medical affairs at Ticonderoga. His duties from that time on took him north, then back to Philadelphia and to the battle of Princeton before he went to Albany. In 1778 he was transferred to the Middle Department of the Continental Army as Deputy Director General and later was placed in charge of the purchasing department for all medical supplies. He died in 1781, at the age of 36, not living to see his country achieve independence.



Mead Johnson is introducing two new low-dose, combination oral contraceptives: OVCON®-50 and OVCON®-35. Described as "low dose" and "lower dose," both are formulated to include norethindrone, a progestogen, in combinations with ethinyl estradiol, the estrogen hormone component.

* * *

Compass Industries announces a new Mark I Van Lift, a second generation. It has heavier bearings to limit side sway, has greater lifting capacity (750 lbs.), 4,000 lb. test safety side straps and other improvements. Compass is also highlighting its "Cadillac of Wheelchairs," a self-propelled model with a range of 25 miles.

* * *

Schering announces a new ointment form. Diprosene Ointment 0.05% contains 0.64 mg of betamethasone dipropionate in a base of mineral oil and white petrolatum. It is indicated for the relief of the inflammatory manifestations of corticosteroid-responsive dermatoses.

* * *

The Sinkette Corporation has a new portable patient care sink designed to facilitate shampoo and other hair care for patients confined to bed or wheel chair. It is light in weight (9 lbs.), is easily moved into place and has a battery operated power-pak.

* * *

Lederle announces recent approval of the use of Artane® in conjunction with levodopa in the treatment of parkinsonism. The dosage of both drugs is lower than it would be if one or the other is used alone. There is a synergism which contributes to relief of tremors and lowering of side effects.

* * *

"The Soft Foods Cookbook" for people with chewing and swallowing problems is now available by mail. Address the author, Anne S. Chamberlain, at 814 Blackstone Village, Meriden, Conn. 06450. The price is $2.33, postpaid.

* * *

News of what is new in the medical supply industry is composed of obstracts from news releases by manufacturers—of pharmaceuticals, clinical laborotory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

Before prescribing, please consult complete product information, a summary of which follows:

Indications: In adults, urinary tract infections complicated by pain (primarily pyelonephritis, pyelitis and cystitis) due to susceptible organisms (usually *E. coli, Klebsiella-Aerobacter, Staphylococcus aureus, Proteus mirabilis,* and, less frequently, *Proteus vulgaris*) in the absence of obstructive uropathy or foreign bodies. **Note: Carefully coordinate *in vitro* sulfonamide sensitivity tests with bacteriologic and clinical response; add aminobenzoic acid to follow-up culture media. The increasing frequency of resistant organisms limits the usefulness of antibacterials including sulfonamides.** Measure sulfonamide blood levels as variations may occur; 20 mg/100 ml should be maximum total level.

Contraindications: Children below age 12; sulfonamide hypersensitivity; pregnancy at term and during nursing period; because Azo Gantanol contains phenazopyridine hydrochloride it is contraindicated in glomerulonephritis, severe hepatitis, uremia, and pyelonephritis of pregnancy with G.I. disturbances.

Warnings: Safety during pregnancy not established. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been reported and early clinical signs (sore throat, fever, pallor, purpura or jaundice) may indicate serious blood disorders. Frequent CBC and urinalysis with microscopic examination are recommended during sulfonamide therapy.

Precautions: Use cautiously in patients with impaired renal or hepatic function, severe allergy, bronchial asthma; in glucose-6-phosphate dehydrogenase-deficient individuals in whom dose-related hemolysis may occur. Maintain adequate fluid intake to prevent crystalluria and stone formation.

Adverse Reactions: *Blood dyscrasias* (agranulocytosis, aplastic anemia, thrombocytopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia); *allergic reactions* (erythema multiforme, skin eruptions, Stevens-Johnson syndrome, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis); *G.I. reactions* (nausea, emesis, abdominal pains, hepatitis, diarrhea, anorexia, pancreatitis and stomatitis); *CNS reactions* (headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo and insomnia); *miscellaneous reactions* (drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon). Due to certain chemical similarities with some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia. Cross-sensitivity with these agents may exist.

Dosage: Azo Gantanol is intended for the acute, painful phase of urinary tract infections. *Usual adult dosage:* 2 Gm (4 tabs) initially, then 1 Gm (2 tabs) B.I.D. for up to 3 days. If pain persists, causes other than infection should be sought. After relief of pain has been obtained, continued treatment with Gantanol (sulfamethoxazole) may be considered.

NOTE: Patients should be told that the orange-red dye (phenazopyridine HCl) will color the urine.

Supplied: Tablets, red, film-coated, each containing 0.5 Gm sulfamethoxazole and 100 mg phenazopyridine HCl—bottles of 100 and 500.

ROCHE

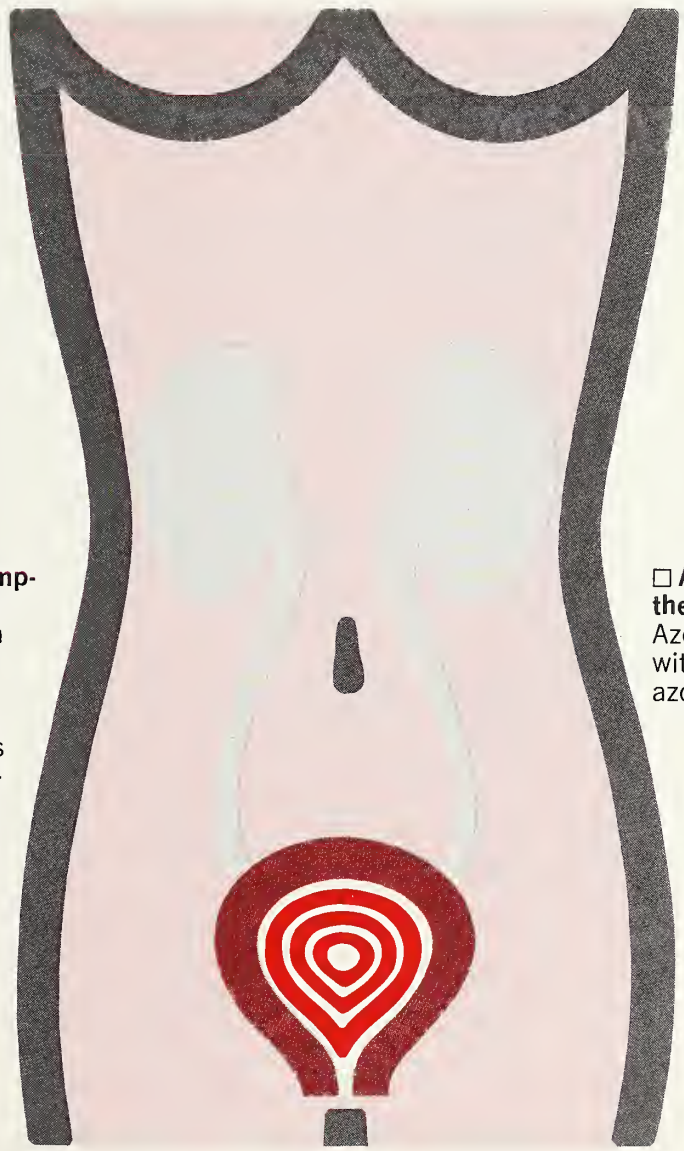
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for the pain for the pathogens



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Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema*. That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension*. Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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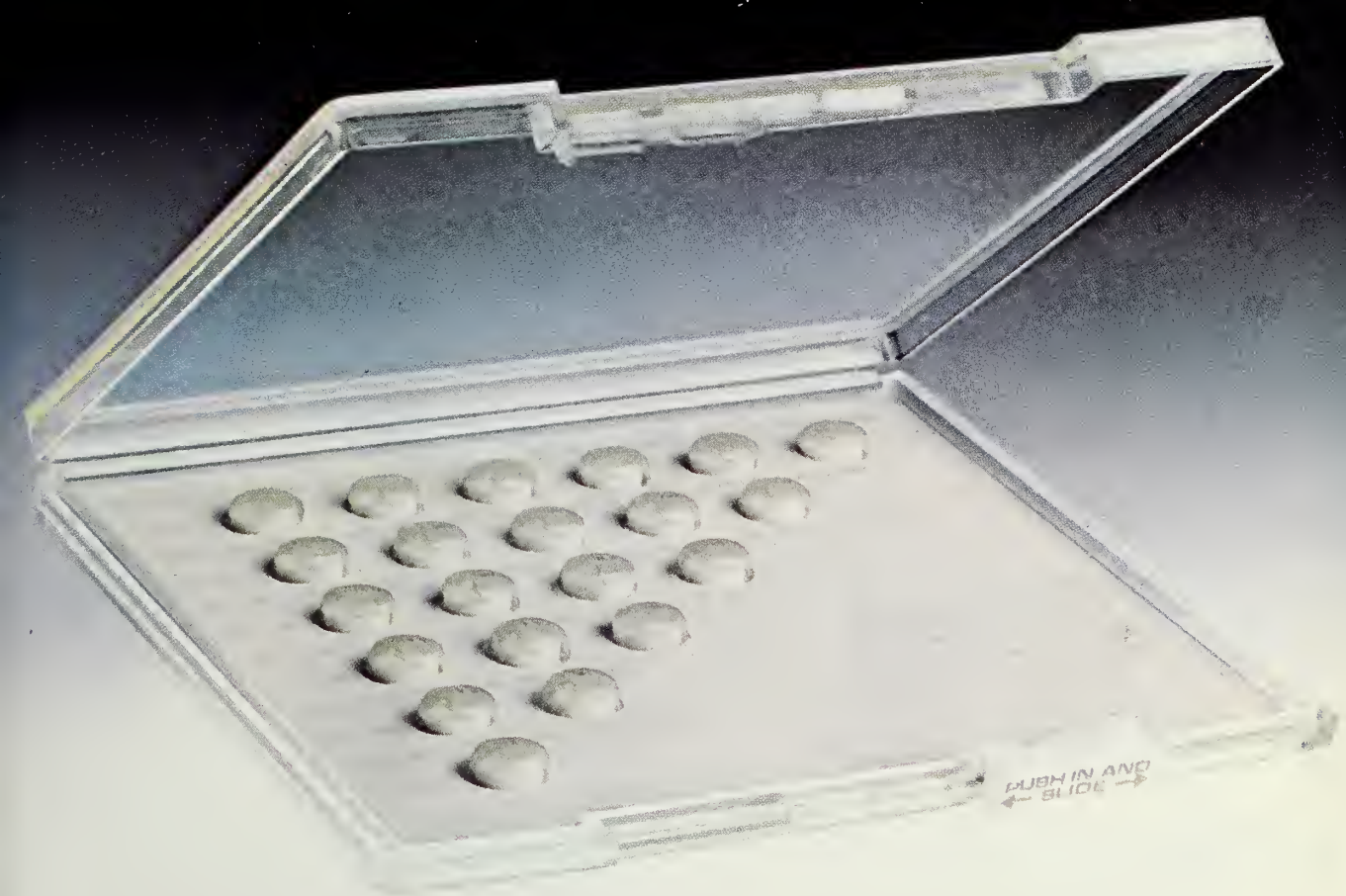
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▪ **Dosage for Vertigo***—The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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History of Early Anesthesia in Indiana

(Part One)

GEORGE M. ROSENHEIMER, M.D.
South Bend

What cannot totally be known, ought not to be totally neglected; for the knowledge of a part is better than the ignorance of the whole.—Abulfeda, Arabian author).

This account of early anesthesia in Indiana is being presented to you with this quotation in mind, because "a part of the history of anesthesia in Indiana is better than the ignorance of the whole." Some of this paper is from proven data, while the remainder is from the memories of many of you, the members of our state society.

Many of the younger generation consider history passé, or for the older generation, but a review of early anesthesia in Indiana may be interesting to them, because from these pioneers of anesthesia in Indiana came about the progress in the scientific field and with it the monetary rewards of today.

This progress has resulted from many things, including the swift evolution of the new field called Anesthesiology, which has grown much faster than any other medical specialty in America.

Some background of early anesthesia, in general, is required to understand the problems of early anesthesia in Indiana.

As you all know, the work of Davy and Farady of England on nitrous oxide; the studies of Jackson, a Boston chemist; also the unsuccessful attempt of Horace Wells to demonstrate anesthesia with nitrous oxide; the ether frolics of Georgia and Dr. Long's administration of ether there; all preceded the demonstration of ether anesthesia at Massachusetts General Hospital in 1846 by Dr. William T. G. Morton, for the relief of pain during surgical operation. Following this great event, anesthesia was not uniformly successful, and these bad results raised the question of the safety of these anesthetic agents, which today is probably our first consideration of their value. James Simpson introduced chloroform in 1848, but the death of a patient under this agent raised the question of the safety of it. In 1868, Andrews of Chicago employed Davy's suggesting that nitrous oxide be mixed with oxygen, thus giving us nitrous oxide-oxygen anesthesia.

In 1876 Clover devised an inhaler for use of nitrous oxide-oxygen and ether and originated the nitrous oxide-oxygen-plus-ether anesthesia. In 1884 Karl Kollar introduced cocaine; in 1885 Corning accidentally introduced cocaine in the spinal canal, and thus spinal anesthesia was discovered. Richardson first used ethyl chloride in 1867, but this did not come into extensive use until 1896. In 1905 Braun introduced novocaine, a substitute for the potent cocaine. In 1917 Cotton described ethylene as a general anesthetic, and Luchhast and Carter reported the first ethylene anesthetics from the Presbyterian Hospital of Chicago in 1920. Waters and Griffith reported on cyclopropane in 1932, and Lundy introduced pentothal anesthesia in 1936.

Indiana became a state of the Union in 1816. Many of its earliest doctors came from the army, especially from the East, by way of the Ohio River, through Vincennes and Old Fort Wayne, now the city of Fort Wayne. Many remained as civilian physicians.

Since our specialty is quite young and a fast growing one; since the first ether anesthetic given in America was in 1846; and since the first anesthetic given in Indiana (as far as I have yet discovered) was given at Indianapolis in 1867, I am using this as a basis for the time of beginning my paper, and ending it about the time of termination of World War II—1948 or 1950, a century later.

Organized anesthesia in this country stems from the formation of the Long Island Society of Anesthetists in 1905, by a group of physician anesthetists, to promote the Art and Science of Anesthetics. This society is the forerunner of the American Society of Anesthesiologists, and is second oldest in the world (London being the first). Increased interest in the scientific sessions and increased requests for membership from outsiders led this society to form the new society known as the New York Society of Anesthetists (1911). Within a year plans began for a National Society of Anesthetists.

In the meantime, another anesthesia organization appeared, the American Association of Anesthetists, formed at a meeting of the American Medical Association in 1912. This was formed by the great figure in organized anesthesia, Dr. Frances McMechan of Ohio. He was the first to accomplish liaison between the basic sciences and clinical anesthesia. He first formed the Interstate Association of Anesthetists (Ohio and Kentucky), acting as organizational secretary; then in 1916 he became secretary of the American Association of Anesthetists, and in 1926 this association was enlarged to become the Associated Anesthetists of the United States and Canada. The Interstate Association became the Mid-Western Association of Anesthetists,



Floyd T. Romberger, M.D.

thus becoming our own regional part of the Association. At the same time, he formed the Eastern, Western and Southern Sections of the Associated Anesthetists of the U.S. and Canada. In 1925, the name was changed to International Anesthesia Research Society and this was the first anesthesia society to publish a journal for its members.

I was the last chairman of our Mid-Western Section, 1939, when all the regional sections were combined into the International Anesthesia Research Society, with an annual meeting for all its members.

Efforts were made in 1925 to secure a Section of Anesthesia in the American Medical Association, but it was not until 1936 that affiliation was accomplished. In 1936, the New York Society of Anesthetists became the American Society of Anesthetists and it, in turn, became affiliated with the American Board of Surgery in 1937. In 1938, the Advisory Board of Medical Specialties approved the affiliation and official recognition of physicians competent to practice and teach anesthesia. Anesthesia, as a specialty, was now an accomplished fact. In 1940, the AMA voted to establish a Section of Anesthesiology, a mission begun many years previously. The ASA House of Delegates was formed in 1948, and our *Journal of Anesthesiology* was established in 1940, the first editor being Dr. Henry Ruth of Philadelphia.

Our own Section of Anesthesia of the Indiana State Medical Association was formed in 1935, the first chairman being Dr. Floyd T. Romberger of Lafayette; vice-chairman was Dr. Charles Combs of Terre Haute, and secretary-treasurer was Dr. Lillian Mueller of Indianapolis. The first meeting was held at Gary, at our State meeting in 1935. Over 100 members attended this meeting.

The Indiana State Section of the American Society of Anesthesiology was founded in 1948. The first officers were:

President: Dr. William H. Lane, South Bend,
Vice-President: Dr. Edward F. Bloemker, Indianapolis,
Secretary-Treasurer: Dr. William B. Adams, Muncie, and
Director of District #13: Dr. George M. Rosenheimer, South Bend.

I was elected the first director of District #12, representing at that time both Illinois and Indiana. Since we did not have 100 members for a district director of our own, Indiana won the toss of the coin, and we received the Directorship for three years. By 1955, however, Indiana had over 100 members and was entitled to have its own District. Dr. Russell Havens of Ft. Wayne was our second director of District #13. This District was changed to #24 in 1957, and in 1959 to District #13.



Charles N. Combs, M.D.



Lillian Mueller, M.D.

In 1934, the attorney general of Indiana was asked by the Indiana State Medical Registration and Examination Board for an interpretation of the Indiana Medical Practice Act, as it pertained to the giving of anesthetics by nurses. He ruled that "administering of anesthetics is a duty to be performed by a *duly licensed* physician only". Also, the Indiana State Board of Registration and Examination stated "that Indiana *does not have* a statute which provides for a physician to assume responsibility for a nurse, or anyone else, to administer anesthetics or to do any type of practice."

In 1934, the hospitals of Indiana received a letter from the Board with this interpretation and with it the order that a reasonable length of time would be allowed for them to replace the nurse anesthetists which they had in their employ. Many hospitals did so at once.

The prevailing fee for anesthesia, at that time, was $5.00 for a so-called minor operation, $10.00 for a major procedure and, occasionally, $15.00 for a very long one. When I began full-time anesthesia in 1931, my fees were $10.00 for minor surgery, and $25.00 to $50.00 for major surgery, regardless of time. It was later that we adopted a time-basis for the anesthetia charge. There were several different methods of collecting our anesthesia fees then. Some billed

their patients directly, as the surgeons did. Some billed the patient with their own bill, but the hospital collected the anesthesia fee along with the hospital bill, and charged the anesthetist a fee for this service. Whenever the anesthetist was hired by the hospital, he was paid a fixed salary, or a salary and commission. Then the hospital retained the rest of the anesthetic fee, which was always added to the patient's hospital bill. Some anesthetists worked for the head of the Department of Anesthesia at a hospital and were paid a salary or commission.

All these methods were a trial-and-error way of a fast growing specialty, with many growing pains, but we were trying to give the patient better anesthesia and give better anesthesia service to the hospitals. Some of these plans were good—many bad—but we were trying and feeling our way along. It was not until 1950, that the AMA and the ASA adopted a "Code of Ethics," which stated:

"The practice of anesthesiology, physical medicine, pathology, and roentgenology are all integral parts of the practice of medicine, in the same category as the practice of surgery, internal medicine or any other designated field of medicine. It is unethical for any practicing physician anesthesiologist to enter into a relationship with any corporation which enables it to offer his services for a fee."

Since this time, nearly all our members are now full-time anesthesiologists, in fee-for-service practices.

Some prominent and early anesthesiologists from the state of Indiana are:

(1) Arthur E. Guedel, (1883-1956), who is often referred to as "the father of modern anesthesia." He graduated from the Indiana University School of Medicine in 1906. He did general practice on the southside of Indianapolis prior to going into anesthesiology. He was the first anesthesiologist at the Indiana University Medical Center, and gave six to eight lectures on anesthesia to the Junior Medical students each year, writing out on the blackboard his "Signs and Stages of Ether Anesthesia." These later appeared in his book and were



Arthur E. Guedel, M.D.

also adopted internationally. Difficulty with Dean Gatch caused his resignation, and he then did anesthesia at St. Vincent, Indianapolis General and the old Protestant Deaconess hospital. His interest in anesthesia began upon his graduation in Medicine; he was particularly interested in the physiological effect of emphysema upon anesthesia. In 1915, he published in the *Journal of the Indiana State Medical Association*: "Nitrous Oxide Anesthesia in Obstetrics." In 1919 he read a paper before the Indianapolis Medical Society: "Third State Ether Anesthesia—Sub-classification Regarding the Significance of the Position and Movements of the Eye-ball." As an officer, he taught anesthesia in France during World War I, riding his motorcycle throughout France, and covering various evacuation hospitals. In 1941 he received the Henry Hickman medal from the Royal College of Medicine in London. He also received the Distinguished Service Award from the ASA in 1950.

Dr. Guedel and Dr. Ralph Waters collaborated on the "To and fro" absorption system and cuffed endotracheal tube anesthesia. This work was done on weekends in 1926 and 1927 on the fourth floor of the old Medical School Building (now Emerson Hall). Dr. Waters would come to Indianapolis to spend the week and they would keep dogs asleep under water, in large tanks up in the laboratory. Dr. Guedel left Indianapolis in 1928 and went to Los Angeles, but he never forgot Indiana and his friends here. His last visit to Indiana was in the fall of 1955; he died June 10, 1956.

(2) Dennis E. Jackson was born at Bridgeport, Ind., in 1878. He received his B.A. in 1906, his Ph.D. in Physiology and Pharmacology in 1908 at Indiana University. He graduated from the Rush Medical School in 1914 with the M.D. degree. He assisted in Physiology at Indiana University in 1904-1906. He was the inventor of the Cardiovibograph (a recording of heart tracings from vibrations of air in the lungs); the original researcher of the closed system of anesthesia with carbon-dioxide absorption and inventor of the first machine in 1914, and he published the first paper on control of carbon dioxide in a closed system in 1915. He also did research on trichloroethylene and invented a machine for its administration.

(3) Joseph Thomas Cary McCallum was born in Australia in 1890. He attended Butler University in Indianapolis, obtaining his B.A. in 1916 and an M.D. from Indiana University School of Medicine in 1926. He wrote early papers on analgesia and anesthetic properties of the barbiturates and strychnine poisoning.

(4) Emery A. (Jack) Rovenstine was born in Atwood, Ind., in 1895 and died in 1960. He obtained his M.D. from Indiana University School of Medicine in 1928. He became interested in anesthesia while doing general practice in LaPorte. He served his residency at the University of Wisconsin General Hospital under the greatest of teachers, Dr. Ralph Waters, and remained two years longer as Dr. Waters' assistant. He became professor of anesthesiology at Bellvue Hospital in New York City in 1932, where he made a national name for himself training many well-known anesthesiologists of the world today.

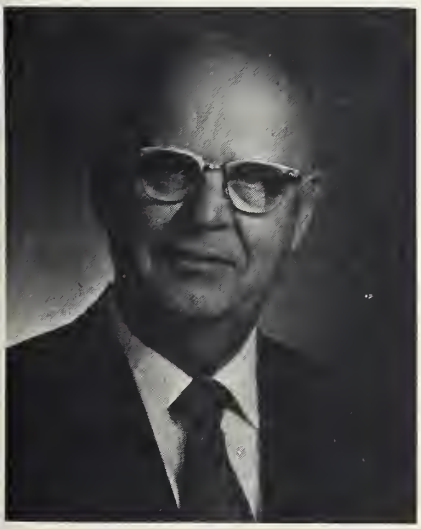
(5) Horace Abbott Shonle (1892-1947) joined the Eli Lilly company as a staff member in Chemical Research, and in 1924 discovered the barbiturate Amytal, and later the barbiturate Seconal.

In 1869-70, Dr. Milton M. Latta of Goshen combined nitrate of amyl and chloroform as an anesthetic and gave several of the mixtures. He also performed the first vaginal hysterectomy in Indiana.

In 1850, at the meeting of the Indiana State Medical Society, a committee consisting of Drs. Davidson, Sloan, Mears, Parry, Dunlap and Harrison, was appointed to report (at the next meeting) on the use of anesthetic agents. In their very excellent report to the session in 1851 (*Transactions of Indiana Medical Society*—1851), he said: "We have heard of no case in Indiana, where death has been connected with the exhibition of chloroform, nor of any disagreeable consequences resulting from its use other than a few hours continuance."

This report was only five years after the discovery of anesthetics and four years after the discovery of chloroform.

The first chloroform anesthetic given in Indiana (as far as I can find) was given in Indianapolis for the "first cholecystotomy" in the world. The surgeon was Dr. J. S. Bobbs of Indianapolis. His description of the procedure does not name



Edward F. Bloemker, M.D.



Horace A. Shonle, M.D.

the anesthetist; only "he was assisted by the Drs. Newcomer, Todd, Comingore, Mears, Moore, Avert and a medical student. The patient being *under the influence* of Chloroform." This was done in a vacant storeroom above a drug store in Indianapolis. Postoperative orders were "three (3) portions of soda and morphia for pain, morning, noon and night; plus 30 drops of laudanum t.i.d. if the potion did not completely relieve the pain." (Case of Lithotomy of Gall-bladder, in *Transactions of Indiana State Medical Society 1868*). Dr. H. Rayford of Evansville, in 1851, favored the use of chloroform in obstetrics.

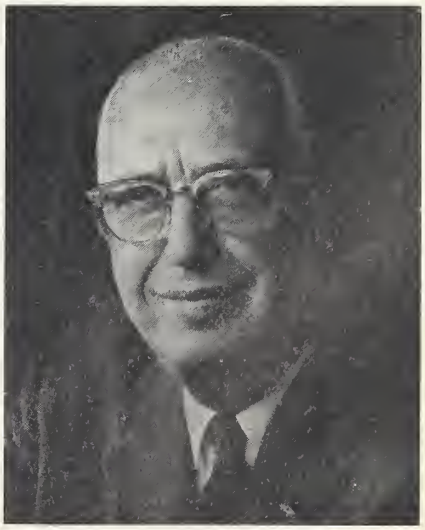
The first ether anesthetic was given in 1869-70 at the old Indianapolis City Hospital. Dr. M. H. Wishard, Sr., was superintendent, and Dr. John Oliver was the intern. (I am quoting Dr. Oliver's story as told to our class in orthopedics in 1924): A healthy, young, male patient with an incarcerated inguinal hernia was selected for the operation. The new ether anesthetic was decided upon. He was placed on the operating table; the ether was given by open-drop method; the patient began struggling at the excitement stage, slipped off onto the floor. When he became unconscious from the anesthetic, now being given to him on the floor (being held down in the corner of the operating room by three or four nurses and doctors), he was once again placed back on the table and the ether continued. The operation was a success. The patient made an uneventful recovery from both the operation and the anesthetic. The anesthetist was Dr. John Oliver, later the first orthopedic surgeon in the Midwest.

When I started full time in anesthesia in South Bend, there were very few physicians doing full-time anesthesia. Probably the first was Dr. Arthur Guedel of Indianapolis. In 1920, Dr. Floyd T. Romberger came to Lafayette. He became quite a "spinal anesthesia" man, giving a course in spinal anesthesia to many physicians over the state. He was the first chairman of our Indiana State Section on Anesthesia in 1935, and also became a president of our own State Medical Association.

Dr. Frank Ratcliff joined Dr. Romberger in 1929 and is still in active practice. They worked at both the Home and St. Elizabeth Hospitals.

Dr. Ernest J. Buckley of Jeffersonville was doing full-time anesthesia in the early 30s. He and I attended many of the early annual meetings of the International Research Society. He also gave anesthetic service to the Tuberculosis Hospital.

I began full-time anesthesia in South Bend in 1931, working at Epworth, St. Joseph, St. Joseph of Mishawaka, and Healthwin (our



George M. Rosenheimer, M.D.

county Tuberculosis Hospital), besides going to several smaller towns in the area.

Dr. Lillian Mueller of Indianapolis, was an otorhinolaryngologist doing part time anesthesia; she became assistant to Dr. John Whitehead at the Methodist Hospital in Indianapolis, in the early 30s. In 1940, she became the head of the Department of Anesthesia at the City Hospital in Indianapolis, devoting full time to her duties there.

Dr. Fred Thomas of Indianapolis graduated in 1924. He took his internship at St. Vincent Hospital, and remained there as anesthetist, also doing General Practice with an office on East Michigan Street. In 1928 he became Head of the Anesthetic Department, teaching the interns and residents full time. He retired Dec. 31, 1970.

There were no residencies in anesthesia in Indiana until about 1932. Dr. John Whitehead began a two-year residency in anesthesia at the Methodist Hospital which was recognized by the American specialty boards. Some of his first graduates were: Dr. William Adams (now of Muncie), 1937-1939; Dr. Wm. H. Lane 1939-1941, now of South Bend; Dr. Edward Bloemker of Indianapolis, and Dr. Merl Liston in 1937.



John M. Whitehead, M.D.

City Hospital of Indianapolis began its residency in anesthesiology about 1940 under Dr. Lillian Mueller, who had previously been at the Methodist Hospital. First resident in anesthesia (1949) was Dr. Richard Russell of Evansville, now deceased.

In 1939, Epworth Hospital of South Bend obtained a residency in anesthesiology; I was director of the Anesthesia Department. Dr. Edson Fish was our first two-year resident, leaving in 1941 to head the Department of Anesthesia at the St. Joseph Hospital in South Bend. Among others who trained here were: Drs. Charles Hamilton, South Bend; Dave Parks (deceased); Kenneth DeVoe, South Bend; Edward Walker, South Bend; Walter Pelczar, Bay City, Mich.; Joseph LaRocca (deceased); Dr. Wallace Hill, South Bend, and several part-time physician-anesthetists of our area. Our residency was discontinued in 1962.—**To be concluded next month.**

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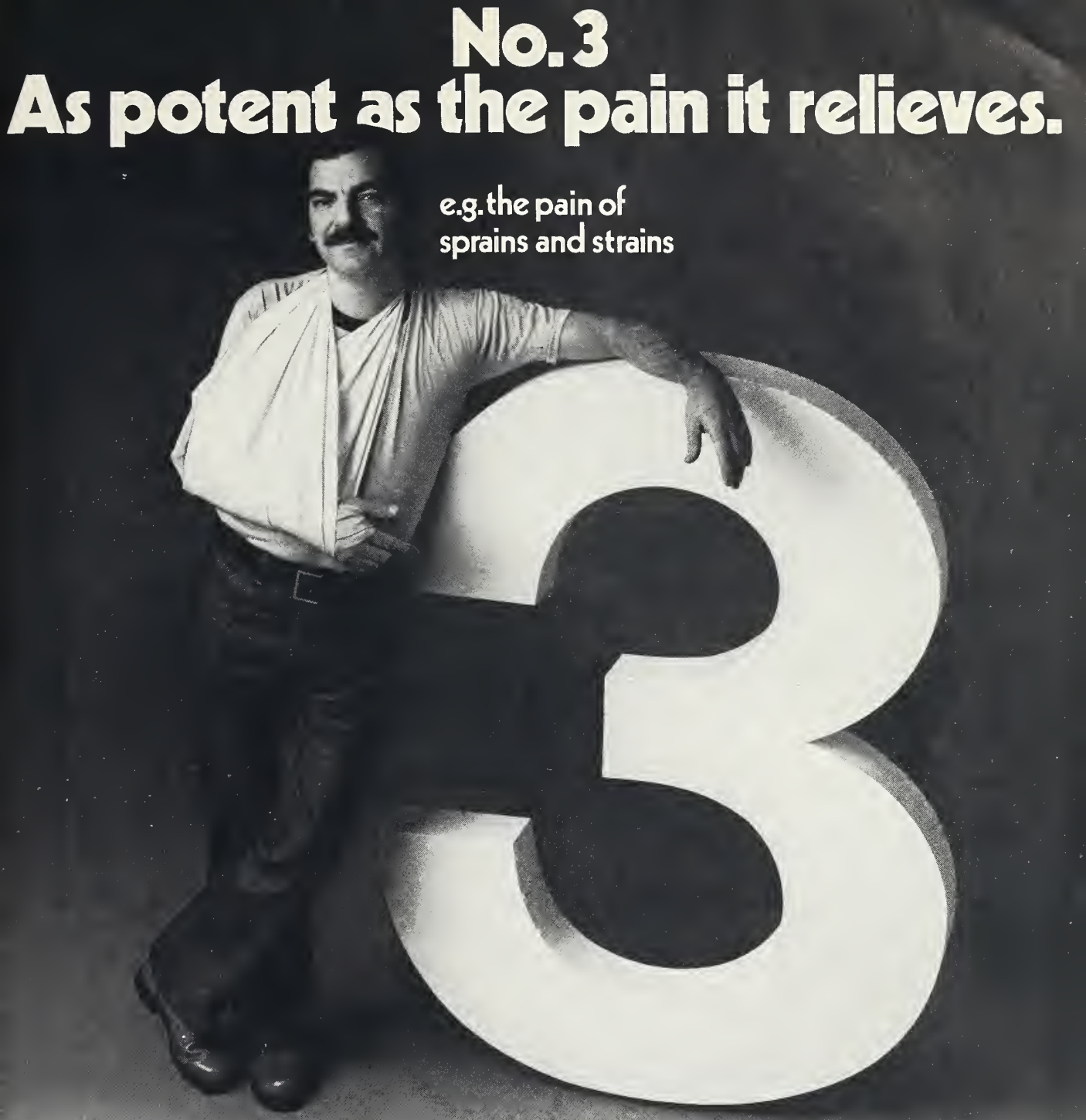
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High Mortality Rate Linked to Ovarian Cancer

The management of patients with ovarian cancer presents a constant challenge to the clinician. This challenge is reflected not so much in the incidence of the disease (25% of gynecologic cancers), but in its high mortality rates (44% of all deaths from cancers of the genital tract).

Thus, while 10 out of every 1,000 women in the U.S. over the age of 40 will develop ovarian cancer, only one or two will be cured.

As in other cancers, early diagnosis is the most effective means of increasing survival rates for women with ovarian cancer.

Unfortunately, the diagnosis of ovarian cancer is more a matter of chance than a triumph of scientific methods. Because there are limited means of detection, careful evaluation combined with constant suspicion is essential, especially in high-risk patients.

Peak incidence of ovarian cancer is found in women between 40 and 65 years of age. The ovary may get too old to function, but it is never too old to form tumors. Women at high risk usually have a long history of ovarian imbalance or malfunction, including increased premenstrual tension, heavy menstruation with marked breast tenderness, a tendency for spontaneous abortions, infertility and nulliparity as well as an early menopause.

For women in the high risk group, the symptomatology often includes vague abdominal discomfort, dyspepsia and other mild digestive disturbances which may be present for several months prior to diagnosis.

It is imperative, therefore, to rule out ovarian cancer in women between 40 and 65 years of age who present with persistent gastrointestinal symptoms which cannot be definitely diagnosed.

Routine pelvic examination will detect only one ovarian cancer in 10,000 examinations of asymptomatic women. In addition, pelvic findings are often minimal or uncertain, even in patients with advanced disease.

A complete workup for ovarian cancer should include: Careful history, physical examination, pelvic exam and pap smear, proctosigmoidoscopy, as indicated, CBC and urinalysis, SMA-12-blood chemistries, chest x-ray, intravenous pyelogram, GI series and barium enema.

Ovarian cancer in children is also a difficult and challenging problem for the clinician. In children, the ovary is the most common site in the reproductive system for tumors; one of every 10 is malignant.

Ovarian neoplasms may occur at any time in childhood or adolescence, but they tend to be more frequent at puberty, between the ages of 10 and 14, thus supporting speculation that release of a control mechanism or pituitary stimulation of a latent factor in the ovary is the triggering device.

Ovarian cancer in a pregnant woman is not a common problem. Less than 10% of all ovarian cancers occur in women under 35 years of age, and most women have had their children by that age. The incidence is only about one in every 18,000 pregnancies. Generally, the management of ovarian cancer in a pregnant patient is the same as that in a non-pregnant patient; if the tumor is low-grade and confined to only one ovary, the pregnancy is usually allowed to go to term.

Smoking Tips for Your Patients

FOUR SMOKING STYLES

Habitual Smoking: Here the smoker may hardly be aware that he has a cigarette in his mouth. He smokes as if it made him feel good, or feel better, but it does neither. He may once have regarded smoking as an important sign of status. But now smoking is automatic.

Positive Affect Smoking: Here smoking seems to serve as a stimulant that produces exciting pleasure, or is used as a relaxant, to heighten enjoyment, as at the end of a meal. Here a youngster demonstrates his manhood or his defiance of his parents. This smoker may enjoy most the handling of a cigarette or the sense and sight of smoke curling out of his mouth.

Negative Affect Smoking: This is sedative smoking, using the habit to reduce feelings of distress, fear, shame or disgust, or any combination of them. This person may not smoke at all when things go well, but under tension, when things go badly, he reaches for a cigarette. These smokers give up often, but when pressure hits them, when there's a challenge, they find it very hard to resist a cigarette.

Addictive Smoking: The smoker is always aware when he is not smoking. The lack of a cigarette builds need, desire, and discomfort at not smoking. With this increasing need is the expectation that a cigarette will reduce discomfort—and the cigarette does give relief—for a moment. Pleasure at smoking is real. The enjoyment of the cigarette, however, is very brief and may be disappointing. For this smoker, tapering off doesn't seem to work; the only solution is to quit cold.

Announcement

The third annual cancer conference for primary care physicians co-sponsored by Methodist Hospital and the American Cancer Society, Indiana Division, Inc., will be scheduled in the spring. Usually the conference is in the fall; this change was made since the Indiana State Medical Association meetings in October are featuring the disease cancer.

WILLIAM M. DUGAN, JR., M.D.
Vice-President, Indiana Division
American Cancer Society, Inc.

12-hour claims
are nothing new.

12-hour relief is.



NEW

Novafed® A Capsules

Each capsule contains pseudo-ephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg.

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.





Clinical studies confirm full 12-hour effectiveness.

For years, patients have heard of drugs providing long-lasting relief. But after six or eight hours, they often run out of relief. And it's too soon to take the next dose.

Now, with Novafed A, Dow introduces a prescription capsule with 12-hour effectiveness in relieving allergy and hay fever symptoms. Placebo-controlled clinical studies show that the high level of decongestant in Novafed A provides relief for as long as 12 hours. At the same time, its antihistamine relieves the patient's itchy eyes and runny nose *without* the excessive dryness of anticholinergic agents.

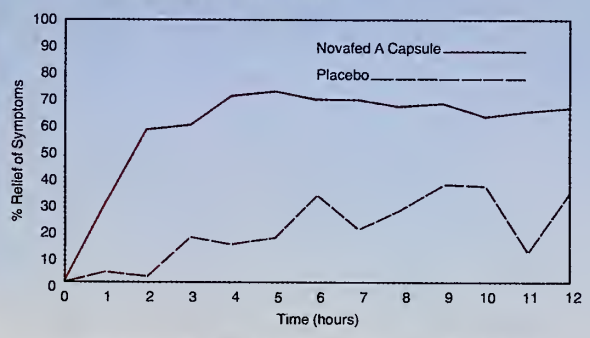
Prompt onset of effect is followed by full 12-hour relief.

(Please refer to the following page for bioavailability studies and prescribing information.)



Patients with severe pollen allergies were tested during hay fever season in a countryside environment and asked to rate severity of five different symptoms on a scale of 1 to 4.

Clinical Study: Degree of Relief from Itchy Eyes and Nose and Throat, Watery Eyes, Runny Nose*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DOW®

Specialists in Cough and Cold Care





NEW

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Each capsule contains pseudoephedrine hydrochloride 120 mg. and chlorpheniramine maleate 8 mg

Controlled-Release Decongestant Plus Antihistamine

It goes the distance.



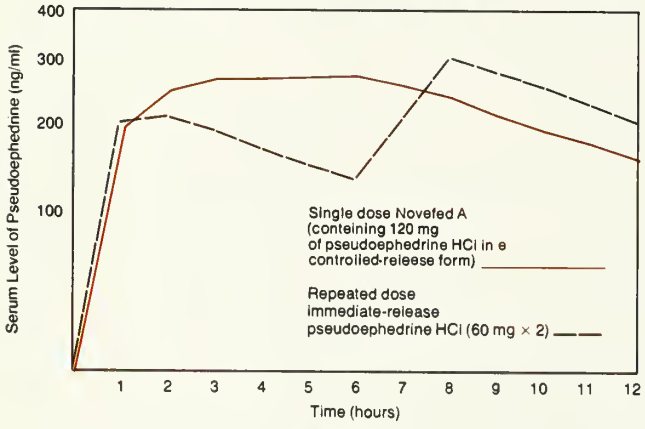
Prompt onset and sustained serum levels over 12 hours.

A bioavailability study confirmed that the sustained 12-hour action of Novafed A was comparable to that of immediate-release medication taken at 6-hour intervals.

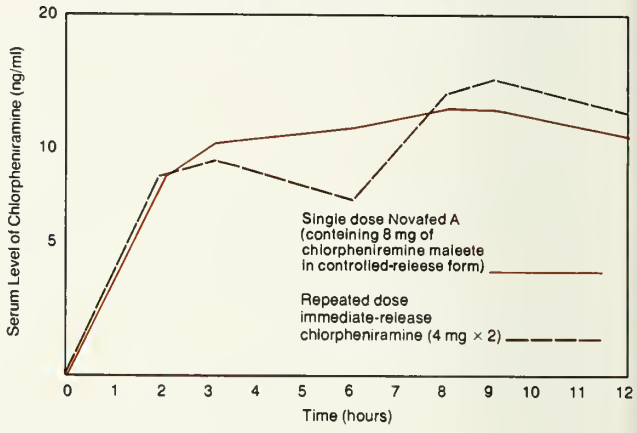
The chart at the left shows the serum levels of pseudoephedrine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 60 mg. pseudoephedrine hydrochloride in an immediate-release form. Serum levels of pseudoephedrine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

The chart at the right shows the serum levels of chlorpheniramine. Initial serum levels following one Novafed A Capsule were comparable to those following a single dose of 4 mg. chlorpheniramine maleate in an immediate-release form. Serum levels of chlorpheniramine over a 12-hour period following a single dose of Novafed A were also comparable to those obtained by an immediate-release form taken every 6 hours.

Comparison of Mean Serum Levels of Pseudoephedrine Following Novafed A and an Immediate-Release Reference Formulation*



Comparison of Mean Serum Levels of Chlorpheniramine Following Novafed A and an Immediate-Release Reference Formulation*



*Unpublished data, Medical Department Files, Dow Pharmaceuticals, The Dow Chemical Company, Indianapolis, Indiana.

DESCRIPTION: Each NOVAFED A capsule contains 120 mg. of pseudoephedrine hydrochloride and 8 mg. of chlorpheniramine maleate. The specially formulated pellets in each capsule are designed to provide continuous therapeutic effect for about 12 hours. Nearly one-half of the active ingredients is released soon after administration and the remainder is released slowly over the remaining time period.

ACTIONS: NOVAFED A combines the action of a nasal decongestant, pseudoephedrine hydrochloride, and an antihistamine, chlorpheniramine maleate. These ingredients are combined to provide prompt and sustained nasal and upper respiratory decongestant and antihistaminic action.

INDICATIONS: NOVAFED A is indicated for the relief of nasal congestion and eustachian tube congestion associated with the common cold, sinusitis and acute upper respiratory infections. It is also indicated for perennial and seasonal allergic rhinitis, vasomotor rhinitis, allergic conjunctivitis due to inhalant allergens and foods and for mild, uncomplicated allergic skin manifestations of urticaria and angioedema. Decongestants in combination with antihistamines have been used for many years to relieve eustachian tube congestion associated with acute eustachian salpingitis, aerotitis media, acute otitis media and serous otitis media. NOVAFED A may be given concurrently, when indicated, with analgesics and antibiotics.

CONTRAINDICATIONS: Symphathomimetic amines are contraindicated in patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy. Antihistamines are contraindicated in patients with narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack, and in patients receiving MAO inhibitors.

Children under 12: NOVAFED A controlled-release capsules should not be used in children less than 12 years of age.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

Hypersensitivity: This drug is contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or antihistamines. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

WARNINGS: Sympathomimetic amines should be used judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy. Sympathomimetics may produce central nervous system stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children. Chlorpheniramine maleate has an atropine-like action and should be used with caution in patients with increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension or in patients with a history of bronchial asthma.

Do not exceed recommended dosage.

Use in Pregnancy: The safety of pseudoephedrine for use during pregnancy has not been established.

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reaction to sympathomimetics. Overdosage of sympathomimetics in this age group may cause hallucinations, convulsions, CNS depression, and death. Therefore, safe use of a short-acting sympathomimetic should be demonstrated in the individual elderly patient before considering the use of a sustained-action formulation.

PRECAUTIONS: This drug should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation.

Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache and nervousness, blurring of vision, heartburn, dysuria and very rarely, dermatitis.

DRUG INTERACTIONS: MAO inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other central nervous system depressants may have an additive effect.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Do not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

HOW SUPPLIED: NOVAFED A is supplied in red and orange colored hard gelatin capsules, monogrammed with the Dow diamond followed by the number 109, in bottles of 100.

Dow®

DOW PHARMACEUTICALS
The Dow Chemical Company
Indianapolis, IN 46268

Specialists in cough and cold care

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Devoted to the interests of the medical profession of Indiana

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3935 N. Meridian, Indianapolis, Ind. 46208

Guest Editorial

The Five Legs of Depression

FROM a psychiatric standpoint, in order for a woman to win in life during her mature years, she must not only know how to intellectually solve living problems, she must also know how to understand and deal with depression. I will discuss some of the dynamics of depression and how this disturbing ego state is related to some of the common major problems with which maturing women have to deal.

Some of the major events which precipitate depression in essentially mentally healthy women are spinsterhood, inability to bear children, marriage to the wrong man, divorce or separation, the empty nest syndrome, and death of her husband or a very close, meaningful person she has lived with all her life. Depression may also be brought on by retirement, or loss of a job due to age, by a life-threatening illness or a disabling illness such as severe arthritis. Menopause does not seem to be of as great importance in producing depression as it was 10 to 15 years ago.

Depression is not the mystery that it used to be. I have found that five major factors are involved in the production of depression. I call these the five legs of depression. Let me describe the five legs of depression, then illustrate the interrelationship between the five legs of depression and the major precipitating events which I have already enumerated. I will then present an actual case history.

One of the five legs of depression is **anger**—anger which is felt toward a person or situation, but which is not expressed but turned inward upon one's self. In my experience, this is the most common major factor producing depression.

A second leg of depression is **guilt or shame** as a result of a forbidden act or omission of an act which morally or ethically should have been performed. Guilt or shame can follow even wishing or fantasizing such a forbidden act. Or one can feel guilt or shame from a forbidden angry wish—such as a death wish for an important person in one's life.

A third leg of depression is that of a feeling of **low self-esteem,** a feeling that you're not very important or that you have failed to achieve your goals in life. Such a poor self-concept can result from loss of a job, rejection by an important person or group or by seeing your children fail in life.

A fourth leg of depression is the real or threatened **loss of a love object.** A love object can be a person, a highly valued job, one's own health, burning down of the family home or anything upon which one places a high positive emotional value. The realization that time is running out can make the loss of youth a lost love object.

A fifth leg of depression is the deep-down fear, which goes back to infancy and childhood, the **fear of being abandoned** or left alone. This is a primitive survival fear which produces anxiety as well as depression, because if abandoned in infancy we would surely die. This leg of depression may result in the clinging-demanding pattern seen in certain depressed persons who fear being left alone even for a moment.

This actual case history involves many of the precipitating events which lead to depression as well as the five dynamic legs of depression.

Mrs. Smith, age 47, a widow of four months, was referred to me from a private sanitarium in a neighboring state for office psychotherapy. She was suffering from depression with some confusion and was experiencing strong paranoid ideas directed toward her lawyer and some family members.

Four months before, just two days before Christmas, her business executive husband failed to come in from removing snow from the driveway. She found his dead body on the snowplow, and immediately went into a state of shock. Her husband, also 47, had just had a complete physical examination for

(From a paper presented at a Workshop on "Winning in Life or Triumphant Maturity" given at the 1976 annual meeting of the Indiana Women's Political Caucus, Indianapolis.)

recurrent chest pain. Bypass heart surgery had been recommended by his internist, but he had rejected such an idea. Mrs. Smith favored such surgery and felt that he should have gotten a second medical opinion.

Mr. Smith had always taken care of financial and legal matters pertaining to their several properties, their investments and taxes, requiring only Mrs. Smith's signature; although she is quite intelligent and fully capable of acquiring practical working knowledge of such matters. Mr. Smith had executed a will and had named a trusted attorney friend as executor of the estate.

Following recovery from the initial shock, Mrs. Smith began to feel quite angry at Mr. Smith for going away and leaving her. She held in her anger at being abandoned, and revealed it for the first time in psychotherapy. She felt entirely alone, in spite of the fact that her two married daughters and three or four older brothers and sisters took turns staying with her.

Two weeks after her husband's death Mrs. Smith became angry at God for taking her husband away at Christmastime. Her relatives repeatedly reminded her of her estate and that it must be taken care of immediately. She became more angry and confused. Since she knew absolutely nothing about such matters, she became angrier at her husband and began to feel like a useless "total fool" and a burden to everyone else.

She had lost a major love object and felt that she was about to lose everything. She felt that that if she couldn't trust her husband, since he left her in such a situation, who could she trust? She became suspicious of the lawyer and of the members of her family. A son-in-law, who is a competent accountant, agreed to take care of her taxes, but she didn't trust him. The healthy part of her personality began to feel guilty and ashamed of her confused paranoid ideas, and her self-esteem dropped lower and lower until she began to verbalize suicidal thoughts. At that point she was placed in the sanitarium.

Mrs. Smith is now essentially symptom-free, and reeducative therapy is directed toward helping her plan a new life for herself. The estate has been settled and her taxes are paid. She is planting a large garden, attending church regularly, intends to join some craft groups, is considering more formal education, thinking about getting a job, and even considering remarriage, since her family is very long lived. Mrs. Smith is going to WIN IN LIFE and enjoy a TRIUMPHANT MATURITY, the Lord willing. **Byron Kilgore, M.D., 106 Three Rivers East, Fort Wayne, 46802**



"She's got to be the world's best typist!"

Editorial Notes . . .

Severe reactions to insect bites should alert physicians and patients to the danger of fatal reaction to a subsequent insect bite. Patients should be warned of the danger. Desensitization should be employed. Since death may occur within a few minutes unless treated, all patients who have suffered a severe reaction and survived should carry an insect sting kit.

The National Board of Medical Examiners will include questions relating to alcoholism in the medical licensing examination in the future. The national examination is now used by all the states.

The National Heart and Lung Institute is conducting a major clinical trial to evaluate what effect lowering blood cholesterol, reducing elevated blood pressure and curbing cigarette smoking has in prevention of first heart attacks and in reducing death rates from coronary heart disease. Called the Multiple Risk Factor Intervention Trial, it involves 20 centers and more than 12,500 volunteers. Duration of trial about six years.

The latest Harris poll shows that people view physicians more favorably than all other sources of medical care. Medical specialists scored 83% favorable, only 9% unfavorable. Physicians in general practice were 72% and 19% in 1968 and are now 81% and 16%. Private hospitals got a favorable rating of 60%, government hospitals only 53%.

Upjohn researchers report that the administration of prostaglandin E_2 in the form of intravaginal suppositories in the cases of women carrying a dead fetus has resulted in the timely expulsion of the fetus. Ninety-eight percent of the patients expelled the fetus within 36 hours. No intrauterine infection was observed.

Methadone treatment of heroin addiction depends on the demonstrated fact that if a heroin addict can be converted to a methadone addict, he or she is free of the addled brain which heroin produces, and is able to hold a job. Thousands of heroin addicts have been rehabilitated, but Dole and Nyswander report that the majority of heroin users are failures. The FDA insisted on limiting the use of methadone to licensed clinics but they have not

attracted or have actually repelled the addicts. Dole and Nyswander say that a good methadone program must have human warmth and must supply effective support of those under treatment. The government clinics have failed in this essential function. The program should have been entrusted to private care facilities originally and should be reoriented in that direction now.

Total Medicaid expenditures increased from 1970 to 1975 by 156%. Twenty-nine percent of this increase was due to more people in the program, 38% was due to more benefits provided and 33% was due to inflation. During same time drug expenditures went up—38% of the drug increase was due to more people, 54%to more drug coverage and only 8% because of inflation. These interesting facts are reported in HEALTH HIGHLIGHTS, published by Eli Lilly and Company. The conclusion is that during the past five years increased prices for retail prescription drugs accounted for only four-tenths of one percent of the total increase in Medicaid expenditures.

Dr. H. Peter Chase, University of Colorado, is recommending that children associated with the five risk factors for atherosclerosis should be tested for cholesterol and triglyceride in childhood. Risk factors are diabetes, obesity, an athletic training diet, symptoms or family history of hyperlipoproteinemia or a heart attack before age 50 in either parent.

NIH research demonstrates that nitroglycerin, either alone or with methoxamine, clearly outperforms several other drug regimens for limiting heart-muscle damage. Nitroglycerin reduces the workload and improves blood supply to ischemic areas. It reduces ischemic damage and protects against development of dangerous arrhythmias.

Eli Lilly Company's "Health Highlights" reports that, in 1974, approximately 200 pharmaceutical manufacturers spent a total of $900 million in promotional activities. This includes product literature, journal advertising, product samples, educational exhibits and presentations, as well as training and salaries for sales personnel. It sounds like a lot in a lump sum but it averages out to $15 per physician per company per year.

The newly organized "American Retired Physicians Association" has found during its early enrollment period that physicians are retiring at a much younger age than formerly. Retirement is being practiced at between 10 and 20 years earlier than in the past. Reasons, when stated, are: paperwork, red tape, government regulations and threat of malpractice litigation.

The General Accounting Office reports that the Social Security Administration spends more money on an average Medicare bill than each of the four private insurance companies which also act as intermediaries for some states. The cost of bills processed by Social Security averaged $12.39 in 1973. Travelers' average was $7.31; Mutual of Omaha, $7.28; Blue Cross of Chicago, $3.81, and Blue Cross of Maryland, $3.55. SSA not only cost a lot more but took longer to pay. And the government wants National Health Insurance in order to lessen the expense of medical care.

International doctors in Alcoholics Anonymous is a non-dues-paying organization of physicians and dentists who get together at least yearly to help each other obtain and maintain their sobriety and freedom from drugs. The next annual convention will be held at the new Los Angeles Marriott Hotel, Aug. 5 through 8, 1976. Tax deductible. Inquiries and newcomers welcome. For information write: Secretary, IDAA, 1950 Volney, Youngstown, Ohio 44511.

Indiana Medical Foundation

The Indiana Medical Foundation was organized to furnish support for the educational activities of the Indiana State Medical Association. These activities include programs for continuing education and the scientific publications of The Journal. Contributions made to the foundation are deductible by donors in accordance with the Internal Revenue Code. Bequests, legacies and gifts are deductible for federal estate and gift tax purposes. Memorial contributions made to the foundation will be formally recorded and acknowledgment will be sent to the family. Gifts, bequests, and memorial contributions may be mailed to the foundation at 3935 N. Meridian St., Indianapolis 46208.



Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D. C. 20005



BOOK REVIEWS

DIET AWAY YOUR STRESS, TENSION AND ANXIETY

J. Daniel Palm, Ph.D., Doubleday & Co., Garden City, New York, 1976.

The author begins with the accepted finding that fructose is metabolized along different pathways than glucose. This fact has led to the rationale for incorporation of fructose in intravenous solutions and to the administration of fructose intravenously in detoxification of alcoholics. But then Dr. Palm takes two rather large steps—first, he assumes that the mechanism of the diseases attributed to stress is established; and second, he maintains that ingestion of fructose will benefit a varied cluster of ailments, some of which have been attributed to stress and some of which have not.

The book, therefore, in the opinion of this reviewer, cannot properly be regarded as "a new common-sense plan for the control of low blood sugar-related disorders including overeating and obesity, migraine headaches, alcoholism, mental disturbances, hypoglycemia, and hyperactivity."

W. D. SNIVELY, M.D.
Evansville

ADULT FITNESS AND CARDIAC REHABILITATION

Philip K. Wilson, Ed.D., editor, University Park Press, Baltimore, 1975; 408 pages with numerous tables and illustrations, 7 chapters and an excellent glossary; conceived and sponsored by the exercise staff of the College of Health, University of Wisconsin, LaCrosse; $19.50.

The diagram of the heart superimposed on an EKG gracefully fills the covering sheet and sets the tone for this interesting effort. While it is on the college—not medical—level, and M.D. could read this volume in his leisure time and glean much knowledge either never learned or long forgotten. I know I did.

In these days of overstrained hearts—or hearts not exercised at all—it is really important for us M.D.s to know just what to expect from the middle-aged, hard-working businessman who just might be working up to the explosive climax of a massive coronary infarction.

The authors use simple language and make their points abundantly clear. The paper, binding and printing are up to the University Park Press usual standards. I saw no typographical errors. I certainly can recommend this volume for a thoughtful M.D.'s perusal in his leisure moments!

ARNOLD LIEBERMAN, M.D.
New York City

THE VITAMIN C COOKBOOK

Cory Ser Vaas, M.D., and Walter Mathews, Doubleday & Co., New York City, 1975; $6.95.

Since the discovery of ascorbic acid by Albert Szent-Györgyi in 1935, some intelligent and thoughtful people are convinced that, because the human organism doesn't store Vitamin C in appreciable amounts, because the pathological lesions of scurvy resemble those of atherosclerosis, or because, like Mt. Everest, it is *there,* large doses are an invaluable aid to good health. Chief among these exponents is Linus Pauling, Ph.D., who wrote the introduction to this volume.

Vitamin C is defined as a "food" here and numerous recipes are presented wherein it is used to flavor and enhance both the taste and the natural occurring amounts of the vitamin. After the introduction there are 11 chapters ranging, roughly speaking, from "soups to sauces." Almost every concoction gets from 1/8 to 1/4 teaspoon of powdered "C" dissolved over the food near the end of preparation. Anyone who has tasted those mouth-watering, cheap orange lozenges from the candy counter will recognize the inimitable smack of Vitamin C.

We have not as yet tried the recipes but they look appetizing in some instances. Who knows—maybe we'll like it!

RODNEY A. MANNION, M.D.
LaPorte

THE CARBO-CALORIE DIET COOKBOOK

Donald S. Mart, Doubleday-Dolphin, Garden City, N.Y., 1976; $1.95.

The Carbo-Calorie Diet quote "Eat hearty, be merry and lose inches" just may work.

The psychology of any diet is most important. In the carbo-calorie diet the dieter may have a variety of tastes with "exchange foods," as is done today in diabetes.

The diet is designed so that one may eat a variety of all foods, including carbohydrates. The secret is "do not eat more than 100 carbo-calories a day." The carbo-calorie diet allows a wide selection of foods.

Carbo-calorie is an artificial value which reflects carbohydrate content and also caloric content. It is determined by a simple mathematical formula.

The recipes, I believe, are very good—and are given in one to eight servings. Many are mouth-watering, even for a non-dieter.

MILDRED R. RAMSEY
Indianapolis

ENERGY TRANSFORMATIONS IN BIOLOGICAL SYSTEMS

Ciba Foundation Symposium No. 31, University Park Press, Baltimore, 1975; 20 separate papers, each discussed at its close, with the meetings closed by a general discussion; 416 pages with numerous tables and illustrations; $19.50.

This symposium is dedicated to Professor Fritz Lipmann, whose photo graces the front page and whose "opening remarks" on "Roots of Bioenergetics" comprise the first chapter.

How is ATP formed in the mitochondria and chloroplasts? How are the phosphoryl groups transferred on the surfaces of the enzymes and across membranes? How are the rod outer membranes excited? What about bioluminescence and the conversion of light energy in the purple membrane of Halobacterium halobium? Just how does ATP act as an energy source for muscular force?

The average practicing M.D. may be interested in scanning this symposium when he has the time. However, this monograph is really aimed at the research workers, medical students and, even, the average professors of medicine in our teaching institutions. As usual, the paper, binding and printing are impeccable: all hospital libraries should have it on their shelves.

ARNOLD LIEBERMAN, M.D.
New York City

The American Society of Contemporary Medicine and Surgery

Presents

An Intensive 20-Hour CME Credit Course on

Current Trends in Cardiovascular Disease

September 17-19, 1976 at
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CHAIRMAN: Leon O. Jacobson, M.D.

This Continuing Medical Education offering meets the criteria for 20 hours of credit in Category 1 for the Physician's Recognition Award of the American Medical Association and for the Certificate of Advanced Medical Studies of the American Society of Contemporary Medicine and Surgery.

PROGRAM

Friday, Sept. 17: Registration 12:00 Noon-1:00 P.M.

1:00 P.M.-5:00 P.M. **JOHN BELLOWS, M.D.:** Welcoming Address; **LEON JACOBSON, M.D.:** Introduction; **LEON RESNEKOV, M.D.:** Overview of CV Disease Today; **HARRY FOZZARD, M.D.:** Cardiac Arrhythmias and Sudden Death; **LEON RESNEKOV, M.D.:** Mgmt. of Cardiogenic Shock; **EARL SILBER, M.D.:** Tmt. of Congestive Heart Failure; ROUNDTABLE DISCUSSION, Q&A, TUTORIAL SESSIONS.

6:00 P.M.-8:30 P.M. DINNER — **OGLESBY PAUL, M.D.:** Prevention of CV Disease

Saturday, Sept. 18:

8:00 A.M.-12:00 Noon: **GARY WILNER, M.D.:** Cardiorespiratory Resuscitation; **JOSEPH MESSER, M.D.:** Eval. of Patients for Coronary Artery Surgery; **JOEL MORGANROTH, M.D.:** Echocardiography; **KENNETH ROSEN, M.D.:** Eval. of Patient with Cardiac Conduction Disease.

12:30 P.M.-1:45 P.M.: LUNCH — **JOEL MORGANROTH, M.D.:** Computerized Echocardiography.

2:00 P.M.-5:00 P.M.: TUTORIAL SESSIONS, SMALL GROUP CONFERENCES.

Sunday, Sept. 19:

8:00 A.M.-1:00 P.M.: **ROGELIO MONCADA, M.D.:** Diagnostic X-Ray in CV Disease; **GEORGE KROLL, M.D.:** Anticoagulants in Myocardial Infarction; **WILLIAM WEHRMACHER, M.D.:** Office Mgmt. of Hypertension; **SUZANNE OPARIL, M.D.:** Hypertension and Sequelae; ROUNDTABLE DISCUSSION, Q&A, SMALL-GROUP CONFERENCES, TUTORIAL SESSIONS.

FEE: $200

(Fee includes Dinner with guest lecture on Friday; Continental breakfast on Saturday and Sunday; and Luncheon with guest lecture on Saturday)

Modestly priced guest rooms are available at the Center.

FOR INFORMATION AND REGISTRATION, WRITE OR CALL:

Richard Muetze
University of Chicago Center for Continuing Education
1307 East 60th Street
Chicago, Illinois 60637

Area Code 312/753-3185

MEDICAL MUSEUM NOTES



SIR Martin Roth, the first Albert Eugene Sterne Visiting Professor, presented a program on Mental Health Care in Britain and the United States on March 12, 1976, in the amphitheater of the Old Pathology Building. This was a most appropriate site to initiate this series since it was here that Dr. Sterne began his own teaching career and where most of his teaching took place.

Albert E. Sterne was born in Cincinnati, Ohio, April 28, 1866. His father, Charles F. Sterne, founder and owner of the Peru (Indiana) Woolen Mills had come to Indiana in 1828 from Wurttemberg, Germany. Albert's mother, Eugenia (Fries) Sterne, was also of German origin.

As a boy Albert attended public schools of Peru and Indianapolis. His secondary education was obtained at Mount Pleasant Military Academy in New York, following which he attended Harvard University, from which he received the B.A. degree *cum laude* in 1887. The following six years were spent in Europe. The M.D. degree was awarded in 1891 by the Friedrich-Wilhelms University in Berlin. Among others, Sterne studied with Jolly, Charcot and Horsley to finish his foreign experience. He returned to Indianapolis in 1893.

Dr. Sterne was a specialist in diseases of the nervous system. In 1898 he organized the Norways Sanitarium (named for the numerous Norway maples that created a park atmosphere of the sanitarium grounds), which continued to function until 1957 when it was sold and later razed.

Dr. Sterne became associated with the Central College of Physicians and Surgeons of Indianapolis and taught neurology and psychiatry in the amphitheater of the Old Pathology Building. After the Central College of Physicians and Surgeons merged with other proprietary schools to form the Indiana University School of Medicine, he continued to teach in the amphitheater and also at City Hospital. Dr. Sterne served as editor of the *Medical Monitor* and associate editor of the *Journal of Nervous and Mental Diseases*. He was president of the Ohio Valley Medical Association in 1910 and of the Mississippi Valley Medical Association in 1913. He was a co-founder of the Indiana Neuropsychiatric Association (now the Indiana Neurological Society and the Indiana Psychiatric Society).



DR. ALBERT E. STERNE (1866-1931)

In 1972 Norways Foundation, Inc., a not-for-profit corporation, presented Indiana University Foundation a gift of securities valued at approximately $345,000 to be used to memorialize Dr. Albert E. Sterne. Three methods were proposed: (1) partial support of the Albert Eugene Sterne Research Professorship in Clinical Psychiatry; (2) partial support of either Junior Faculty Fellows or senior residents in pursuit of training and experience in clinical research, and (3) to provide for a visiting distinguished professorship. This latter proposal was initiated this year, Sir Martin Roth being the first Albert Eugene Sterne Visiting Professor.

Sir Martin is Professor of Psychological Medicine at the University of Newcastle-upon-Tyne, and is perhaps best known for his work on mental disorders associated with aging and for his textbook, *Clinical Psychiatry* (with Meyer-Gross and Slater). ◄



SIR MARTIN ROTH, first Albert Eugene Sterne Visiting Professor, in the omphitheater of the Old Pothology Building. (Photo courtesy Jomes J. Brown, Ind. Dept. Mental Health.)



Handicapped Services Directory Published by State Health Board

The Fifth Edition of the Directory of Services for the Handicapped Indiana, 1976, has been published by the Commission for the Handicapped and the Indiana State Board of Health.

The book contains information concerning public and private agencies and institutions offering services for the handicapped. Information such as General Purpose and Function, Address, Phone, Administrative Officer, Type of Organization, Persons Served, Application Procedure, and how financed is given.

Physicians may request a copy by writing or calling the Commission for the Handicapped. State Board of Health, 1330 W. Michigan St., Indianapolis 46206; phone 317-633-5680. There is no charge.

Appointed to Medical Licensing Board

Dr. Isadore J. Kwitney, Indianapolis, has been appointed to the Indiana Medical Licensing Board (formerly the State Board of Medical Registration and Examination), Governor Otis R. Bowen, M.D., announced recently.

Dr. Reyes Named Fellow of ACS

Dr. Joseph L. Reyes, Princeton, was elected to Fellowship in the American College of Surgeons at the group's recent annual convocation in San Francisco.

Hospital Medical Staffs Elect

Dr. Charles W. Hachmeister has been elected president of the Medical Staff of Deaconess Hospital, Evansville. Others elected were **Dr. Edward L. Brundick,** president-elect, and **Dr. John A. Bizal,** secretary-treasurer. Elected to serve two-year terms as at-large members to the Medical Staff Executive Council were **Drs. William H. Allen, Larry L. Cox and Walter B. Hassel.**

Dr. Charles E. Austin was recently elected president of the medical staff of Community Hospital, Anderson. Others elected to serve with him are **Drs. John D. Jones, Donald P. Bixler, and Gerald P. Irwin.**

Health Board Appointments Made

Serving on the Howard County Health Department Board, which exercises jurisdiction over both city and county health matters, are **Drs. Myrle E. Artis and Alan J. Adler.**

Dr. John Read, Chesterton, was recently appointed to the Porter County Health Board by the mayor of Portage.

Dr. Shaw Certified by Anesthesia Board

Dr. Matthew C. Shaw, Muncie, has been notified by the American Board of Anesthesia that he has completed certification requirements.

Award Winning TV Series to Continue

MEDIX, the Emmy Award-winning, public service television series, will be continued as a weekly TV show this year. The Burroughs Wellcome Company is the sponsor. MEDIX has had an extremely successful year on a national basis. It was first produced country-wide in January 1975, after three good years in Los Angeles. Each weekly program deals with a subject that is of interest to most individuals—the series provides useful and factual health information. It is produced in cooperation with the Los Angeles County Medical Association which has a committee to authenticate the program content.

Dr. Loh Elected President of Society

Dr. Wei-Ping Loh, Gary, was recently elected president of the Asian-American Medical Society, the membership of which consists of licensed physicians of Asian origin. All Asian countries are equally represented on the Advisory Board of the Society.

Directory of Group Meetings Offered

Recovery, Inc., the Association of Nervous and Former Mental Patients, has just issued its 1976 Directory of Group Meeting Information. It is for the individual use of Recovery members in locating group meetings, and is available to professional persons, counselors, agencies and other organizations on approval from an area leader or headquarters. It is primarily for purchase by Recovery members at the price of $1.00. Write to Recovery at 116 S. Michigan Ave., Chicago 60603.

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Continuing Medical Education

More than 100 Indiana physicians are recent recipients of the coveted AMA Physician's Recognition Award. Among those who completed requirements for the award in March are:

Steven Dale Atkins, Greenwood; Stewart Dale Brown, Albany; Fred W. Dahling, New Haven; Robert David Deitch, Beech Grove; William Edward Dye, Oakland City; Mark Lewis Dyken, Indianapolis; Jay S. Fleishman, Kendallville; Gerald Joseph Frankel, Indianapolis; William J. Glover, Gary; Robert Jay Goldstone, Gary; Kenneth Lee Gray, Speedway; Ray Allen Haas, Greenfield; John Franklin Habermel, New Albany; Karleen Bascom Hammitt, Madison; John Thomas Haynes, Indianapolis, and Norman N. Holtzman, South Bend.

Also, Russell Miller Hummel, Marion; Gerald Port Irwin, Alexandria; Ernest Bernard Jankowski, South Bend; Walter T. Jurgensen, Fort Wayne; Charles Ross King, Anderson; Wesley Allen Kissel, Indianapolis; Kenneth William Koss, Muncie; John Eugene Krueger, Fort Wayne; Richard M. LaSalle, Wabash; John David Lind, Anderson; Werner L. Loewenstein, Terre Haute; William C. Luther, Elkhart; Charles Roger Lyons, Wabash; Jon David Marhenke, Indianapolis; Marvin L. McClain, Scottsburg; Frank C. McDonald, New Castle, and Robert A. McDougal, Indianapolis.

Other March achievers are: William K. McGarvey, Indianapolis; Harry G. McKee, Rushville; William Bradley Moores, Indianapolis; George Gordon Morrison, Lawrenceburg; Arthur Lee Moser, Warsaw; Robert Winston Mouser, Indianapolis; James Richard Paff, Muncie; Gun Sil Paik, Michigan City; Yoo Ja Paik, Michigan City; William Ray Powers, Lyons; Julian D. Present, Evansville; Ralph Lewis Rea, Greenfield; John Joseph Reed, Hobart; George Marvin Reul, Kokomo; Merrill A. Ritter, Indianapolis; Frederic L. Schoen, Fort Wayne; Richard Lee Schultheis, Indianapolis; Gerald M. Sinkovic, Indianapolis; Stephen C. Spicer, Rensselaer; Harold E. Stoner, Bloomington; William R. Storer, Indianapolis; Alan Willner, Clarksville; Robert Allen Wolf, Gary, and Joseph William Young, Greenwood.

April Winners

The following physicians qualified for the award in April:

Wallace Morgan Adye, Evansville; Amos Arney, Michigan City; Richard Gerard Bilodeau, Tipton; Robert L. Burton, Gary; Eric Daniel Clark, Plainfield; Gerald Mayson DeWester, Indianapolis; Russell Alois Eckert, Logansport; William Robert Fortner, New Albany and Terry Lee Frederick, Carmel.

Also, William Young Golden, Jeffersonville; Harold Riley Griffith, Fort Wayne; Donald Lurve Hall, Petersburg; Thomas G. Hamilton, Columbia City; George Klutinoty, Carmel; Robert M. LaSalle, Wabash; Mario Leon, Jasper, and Karl L. Manders, Indianapolis.

Other April achievers are: Frances Joan Masser, Jeffersonville; Luciano Pestanas Musngi, Pendleton; William Alfred Paff, Elkhart; Daniel Theodore Ramker, Hammond; Louis Frank Romain, Fort Wayne; James Robert Roth, Wolflake; N. Philip Shelton, Vincennes; Hubert L. Silvero, Fort Wayne, and George Francis Slama, Crown Point.

Also, Robert D. Smith, Lowell; Philip J. Snodgrass, Indianapolis; James J. J. Sprecher, LaPorte; Donald R. Sugarman, Fort Wayne; Victor Jose Tadatada, Salem; Millard Reed Taylor, Howe; Richard W. Wagner, Huntington; Paul Allan Williams, Rensselaer; Mark Wisen, Bloomington; Nelson Albert Wolfe, New Albany; Robert Emmett Wrenn, Bloomington, and Frank H. Zahrt, LaPorte.

Sudden Death Syndrome Study Planned

Dr. Douglas P. Zipes, director of cardiovascular research at the Krannert Institute of Cardiology, and his laboratory are among seven in the United States selected by the National Institutes of Health to collaborate with a team of their counterparts from the Soviet Union in the study of the Sudden Death Syndrome. It is a part of a broad study of various manifestations of heart disease involving seven teams of American and Russian scientists.

Dr. Sprague Gardiner Honored

Dr. Sprague Gardiner, Indianapolis, was recently honored by selection as one of 11 top U.S. physicians listed in United Airlines *Mainliner* magazine as belonging to "an energetic outspoken collective of medical professionals who will be addressing themselves to the issues in their profession."

Film on Treatment of Angina Offered

Ayerst Laboratories has added a film to its audiovisual library—"The Angina Patient: Maintaining Optimal Function." It presents discussion of treatment methods for moderate or severe angina. A 3/4-inch videocassette tape is also available, if preferred. Write Ayerst at 685 Third Avenue, New York City 10017, with three choices of dates for borrowing either the film or videotape.

Dr. van Hoek Named Associate Dean

Dr. Robert van Hoek, assistant surgeon general for the United States Public Health Service, has been named as associate dean in the Indiana University School of Medicine at Indianapolis.

Dr. van Hoek will be assigned the responsibility of medical director of Wishard Memorial Hospital, which has been under the medical management of the School of Medicine for the past year.



Hoosier Physicians Honored For Deeds, Careers, Service

News of the honoring of a number of Indiana physicians in a variety of ways and for many different reasons has been featured in the newspapers of Indiana recently.

A "This Is Your Life" presentation at the Brownsburg High School on Apr. 9 honored **Dr. Arthur Nelson Scudder,** 67, who has practiced in Brownsburg 43 years.

Dr. King S. Jones, Michigan City, was honored at a recent testimonial dinner at which announcement was made of the establishment of a scholarship fund in his name.

Dr. Robert P. Acher, who has had a general medical practice in Greensburg since 1945, was honored recently for his contributions in working with numerous Decatur County health groups.

Dr. Forrest Buell was recently honored for his many contributions to Clay City since he began his practice there in 1959.

The **"Dr. K. M. Lehman** Appreciation Program" held recently at Topeka drew a large crowd of well-wishers, including many "babies" he helped deliver during his 36 years of practice in La Grange County.

In honor of his 74th birthday and his 50th year in the medical profession, **Dr. Loren E. Jennings, Garrett,** was the guest of honor at an open house at the American Legion home in Garrett recently.

The Elkhart Noon Exchange Club recently awarded its highest honor to **Dr. James D. Finfrock,** chief of surgery at the Elkhart General Hospital. He was selected to receive the "Book of Golden Deeds" award and cited as the "sparkplug" of Elkhart's emergency medical technician program.

Dr. Carl Martz, Indianapolis, received the "Good Sam" Samaritan award for his "meticulous concern" for educating and training people to staff Indiana's emergency medical services at the annual meeting of Indiana Health Careers, Inc.

Dr. Glenn W. Baker, Brownsburg, was honored as the 1976 distinguished Grace College alumnus of the year at the school's recent commencement exercises. He has served on the Board of Trustees since 1971 and on the executive committee since 1973.

The Evansville Downtown Kiwanis Club has installed **Dr. Robert J. Fenneman** as president.

Mitchell's Dr. J. R. Hamilton was the subject of the *Bloomington-Bedford Herald-Times* "Sunday Profile" recently. At 77, he said he has no plans for retirement until he reaches 80, when he will "sit down and think about it."

The board of directors of Blue Shield of Indiana has re-elected **Dr. Joseph M. Black, Seymour,** chairman of the board.

Dr. Guy A. Owsley, Hartford City, was recently featured in a story in *Grit*, a national weekly newspaper.

The 98th birthday of **Dr. Charles C. DuBois,** Warsaw, was highlighted in a recent issue of the Warsaw *Times-Union.*



DR. MAX S. NORRIS, Indianapolis, was recently named recipient of the Silver Buffalo Award, highest award for volunteer service to youth presented by the Boy Scouts of America. The award was made during closing ceremonies of the Scouts' National Council meeting.

Dr. Norris was also elected to the Scouts' National Executive Board.

Dr. Leon Gray, Martinsville, was honored recently at a meeting of the Kiwanis Club, on the occasion of his retirement from active practice. Dr. Gray will continue to serve as County Health Officer.

The following week the Kiwanians presented a plaque to **Dr. Maurice Turner, Martinsville,** anesthesiologist at the Morgan County Memorial Hospital in appreciation of his many years of service to the community.

On the occasion of his 80th birthday, the *Columbus Republic* featured a story about the life and practice of **Dr. Walter Scott Fisher,** Columbus cardiologist.

The 1976 Distinguished Fellow Award of the American College of Cardiology was presented to **Dr. B. L. Martz, Indianapolis,** at the group's 25th annual scientific session.

Dr. Wei-Ping Loh, Gary pathologist, has been selected for listing in the 1976 edition of Marquis' *Who's Who in the World.*

Dr. Mary Carroll, Crown Point, was selected as one of the "most valuable women in Lake County" at a recent luncheon sponsored by the Tradewinds association.

Board Certifications Announced

Dr. Tzeng-Chih Chen, Evansville, has been certified in neurology by the American Board of Psychiatry and Neurology, according to a recent announcement.

Dr. Kirby B. Tarry, Columbus, has received word of his certification in urology by the American Board of Urology.

Grant Awarded by Hartford Foundation

The John Hartford Foundation announces the payment of a grant of $13,663 to Indiana University School of Medicine in support of "A search for evidence of cytoplasmic inheritance in man" under the tutelage of Dr. J. C. Christian.

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Orthopaedic Advisory Committee Formed

Members of the Indiana Orthopaedic Society formed an Advisory Committee when they held their annual meeting in April. The various subcommittees and their chairmen are:

Recruitment and Manpower—**Dr. Donald Kettlekamp;**
Rehabilitation Services—**Dr. Carl D. Martz;**
Governmental Agency—**Dr. Frank Throop;**
Cost Control—**Dr. J. Neill Garber;**
Quality Assurance—**Dr. Robert Kimbrough;**
Medical-Legal—**Dr. Bryant Bloss.**

Physicians Announce Retirement

Among Hoosier physicians who have recently announced their retirement are the following. The number of years each was in practice appears in parentheses.

Dr. Frederick C. Schwartz, Kokomo (29)
Dr. Dorothy Teal, Columbus (42)
Dr. Dale D. Dickson, Greensburg (43)
Dr. A. W. Cavins, Terre Haute (50)
Dr. Jacob Rosenwasser, Mishawaka (41)
Dr. John H. Barrow, Dale (44)
Dr. Samuel Bechtold, South Bend (40)
Dr. Jeraldine Baumgartner, Fort Wayne (46)
Dr. Frederic L. Schoen, Fort Wayne (30)
Dr. Thomas O. Dorrance, Bluffton (38)

Dr. Bastnagel Becomes ACP Fellow

Dr. William F. Bastnagel, Indianapolis, was honored by admission to Fellowship in the American College of Physicians during a recent meeting of the College's Board of Regents.

Occupational Medicine Award to Dr. Bundy

Dr. Merle Bundy, who received his M.D. degree from Indiana University School of Medicine in 1942, and who served as Chief of Tuberculosis Control for the Indiana State Board of Health for several years, and who is now Director of Industrial Medicine for United States Steel Corporation, has been awarded the 1976 Meritorious Service Award of the American Occupational Medical Association.

Indiana University Honors Dr. Miller

Dr. Roscoe E. Miller, Indianapolis, has been promoted to the rank of distinguished professor of radiology in recognition for ability, leadership and outstanding achievement.

Notice to Indiana Physicians

Clinical research is in progress at the Indiana University School of Dentistry in the bleaching of tetracycline stained teeth, discolored teeth affected with fluorosis and other causes of tooth discoloration.

The Endodontic Department would be pleased to cooperate with patients so affected and they could be referred to their family dentist or the Endodontic Department would be pleased to assist in treating such patients.

For examination, please call 264-2403, Department of Endodontics, Indiana University School of Dentistry, 1121 W. Michigan St., Indianapolis 46202.

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Final Plans for Convention In October Being Completed

Programs and other elements of the Indiana State Medical Association Convention are falling into place for the annual October meeting. For your information, following is the schedule of events. We've deliberately omitted times and other details of meetings since there may be some changes in scheduling, but these will be provided to you in total detail within the next few weeks.

The meeting is planned for Oct. 9 through 12 and most events will take place in the Indianapolis Hilton.

Special interesting programs are also being planned by the Auxiliary and these will also be publicized for your information.

Make your plans today to attend the Convention.

SATURDAY, OCT. 9, 1976

— Board of Trustees, Reception and Dinner
— Board of Directors, American Association of Medical Assistants, Indiana Society

SUNDAY, OCT. 10, 1976

— Practice Management Workshop
Clayton L. Scroggins Associates
— American Association of Medical Assistants, Indiana Society Meeting
— ISMA Executive Committee Meeting
— ISMA Board of Trustees Meeting
— First Meeting—House of Delegates
— Reference Committee Meetings
— Meeting—Association of American Physicians and Surgeons

MONDAY, OCT. 11, 1976

— "Meet the Professor" Programs
— Section on Surgery Meeting
— IMPAC Luncheon
— General Scientific Program
— Fifty-Year Club Reception
— President's Reception and Dinner

TUESDAY, OCT. 12, 1976

— Section Meetings
- Internal Medicine
- Family Practice
- Radiology
- Pathology and Forensic Medicine
- Medical Education
- Public Health and Preventive Medicine
- Allergy
- Urology

— Final Meeting—House of Delegates

MEETING CONCLUDES

Methodist Hospital Announces Schedule

Courses to be given by the Methodist Hospital, Indianapolis, Graduate Medical Center, have been announced, as follows:

Date	Lecture/Program	Place	Speaker
1976			
Sept. 10-12	Third Annual Cancer Symposium	Clarksville	To be announced
Sept. 17	Psychiatry/Neurology Lecture	Methodist Hospital	Dr. Silvano Arieti
Sept. 22	Genetics in Medical Practice	Methodist Hospital	Dr. Laird Jackson
Oct. 6-7	Current Concepts in Critical Care	Stouffer's Downtown, Indianapolis	To be announced
Oct. 22	Psychiatry/Neurology Lecture	Methodist Hospital	Dr. Barry Blackwell
Nov. 19	Psychiatry/Neurology Lecture	Methodist Hospital	Dr. Nathan Kline
1977			
Jan. 27	Psychiatry/Neurology Lecture	Methodist Hospital	To be announced
Feb. 18	Psychiatry/Neurology Lecture	Methodist Hospital	To be announced
Mar. 18	Psychiatry/Neurology Lecture	Methodist Hospital	To be announced
Apr. 22	Psychiatry/Neurology Lecture	Methodist Hospital	To be announced

International Physicians to Convene

The American College of International Physicians, Antonio B. Donesa, M.D., of Fort Wayne, president, will hold its first Annual Convention in Chicago on Oct. 16 and 17. Fellowship in the College is open to all physicians who received their medical education in schools outside the U.S.

Symposium on "Insect Allergy"

"Insect Allergy" will be the subject of a half-day symposium on Oct. 26 from 2 p.m. to 5 p.m. as a part of a combined meeting of the Pan American Medical Association and the Florida Allergy Association. Dr. Claude Frazier will conduct the symposium which meets at the Diplomat Hotel in Hollywood, Fla.

Newborn Symposium Scheduled

The University of Louisville will conduct the Tenth Annual Newborn Symposium on Nov. 4 and 5 at the Health Sciences Center Auditorium, Abraham Flexner Way, Louisville. For full information write Dr. Billy F. Andrews, 200 E. Chestnut, Louisville 40202.

Pediatric Neurology Course at Milwaukee

A continuing education course in pediatric neurology will be conducted by the Medical College of Wisconsin on Nov. 8 and 9. For complete information write Dr. Jerome V. Murphy, 561 N. 15th St., Milwaukee, Wis. 53233.



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Art, Hobby Show Planned For ISMA Annual Meeting

Space will be provided at the 1976 annual meeting of the Indiana State Medical Association, Oct. 10, 11 and 12 at Indianapolis, for an Art and Hobby Show.

Members of the ISMA and their wives are invited to participate. Information regarding this year's show may be obtained from:

Indiana State Medical Association
3935 North Meridian Street
Indianapolis 46208

It will be the responsibility of each exhibitor to see that his work gets to and from the Indianapolis Hilton, Ohio and Meridian Streets, Indianapolis. (The final arrangements will be provided by the committee.)

IT WILL BE NECESSARY THIS YEAR FOR EACH HOBBY SHOW PARTICIPANT TO BREAK DOWN HIS EXHIBIT EACH EVENING FOR SECURITY REASONS. LOCKED STORAGE SPACE WILL BE AVAILABLE.

ISMA will provide suitable display facilities, but each exhibitor is responsible for transportation costs or any other such expenses involved in entering his exhibit.

In order that the committee may do its best in fulfilling the needs of your exhibit, it is ESSENTIAL that you accurately indicate below the amount of space required for your exhibit.

All exhibits must be labeled with your name and address and each should be titled.

We do not encourage rare or valuable exhibits, because their safety cannot be insured.

In order that the committee may be adequately prepared for your exhibit, **ALL** applications must be submitted no later than Sept. 27, 1976.

We solicit your exhibit to make this year's show the most successful.

APPLICATION for SPACE in ART and HOBBY SHOW

Exhibitor _____ Total number items to be exhibited _____

Address _____

Telephone No. _____

CATEGORY*	TITLE	SIZE or SPACE REQUIRED

MAIL TO:

Indiana State Medical Association
3935 North Meridian Street
Indianapolis, IN 46208

DEADLINE for submission of application is SEPT. 27, 1976

* Please indicate whether your exhibit is oil, watercolor, photography, sculpture, or arts and crafts, etc.

The Woman's Auxiliary Reports to ISMA



On April 22nd at Clarksville, during the 32nd annual House of Delegates meeting and following a beautiful luncheon, Mrs. Erle Wilkinson, president of the American Medical Association Auxiliary, installed the officers of the Indiana State Medical Association Auxiliary for the 1976-1977 year. This was the culmination of two and a half days of year-end committee and state reports, stimulating programs and workshops, and a keynote address by our honored guest, the national president.

My own Grant County Auxiliary members served as hostesses for this exciting day. The members dressed as Southern Belles, received guests and members at the door, and handed each of them a potted mariGOLD. The message on the container, brushed with gold leaf, read "Grant County Welcomes You Aboard the Journey into the Golden Year 1977." The Southern Belles composed a song, "Up in Grant County" and sang it to the tune of "On Top of Old Smokey":

Come up to Grant Coun-ty
It's a great place to go.
Come up ta Grant Coun-ty
Home of ou-r gal Chlo.
We'll wine you and dine you,
Make you glad you came.
So you'll come to Grant Coun-ty
We're gonna tell you our fame:
When Clark founded Clarksville
And made it his home,
'Way up in Grant Coun-ty
Miami In-di-ans roamed.
We had a great battle
In the 1812 war

'Way up in Grant Coun-ty
By the Miss-iss-in-e-wa.
We once had great gas wells
Our sky glowed so bright
As we foolishly burned the
Gas lights day and night.
We now have no gas wells
But we're do-ing just fine
For we have a GOLD-smith
And she's a gold mine.
So come up to Grant Coun-ty
When next April is here.
Come up to Grant Coun-ty
In our GOLD-en year.

In my acceptance speech I stressed:

the medical auxiliary can be invaluable by placing emphasis on *communications* . . . with the membership, with the medical society, and with the public;

the auxiliary can be instrumental in counteracting the excess of news items on the issue of malpractice and insurance, by stressing to the public that the doctors' prime time is devoted to healing, that the doctors contribute enormously to the health and welfare of their individual communities and to society in general.

I further indicated that the continuing goals for the 50th year of the medical auxiliary would be guided by the ever-present need for funds for medical education, by effective action needed in the area of legislation concerning American medicine, and by demands to keep the good American life. As the newly installed president I concluded:

We can be proud of our past achievements of the medical auxiliary; spurred on by the cherished dreams we all have for the future we are confident we will not allow those dreams to lie idly in the files.

The GOLDEN YEAR is our theme. We will join together in making 1976-1977 a GOLDEN one.

Chloe A. Goldsmith

Chloe (Mrs. David A.) Goldsmith
President, ISMA Auxiliary

THE FAMILY LAWYER

Backyard Pools

Kindly Mr. Norris allowed the neighbors to use the swimming pool in his backyard. One day, while he was away from home, a teenage girl dove in from the top of the bathhouse and injured her arm.

In short order Norris found himself on the target end of a damage suit. The injured girl claimed that he should have posted a warning sign against high dives.

But the court found no such obligation, pointing out that Norris had no reason to expect his bathhouse to be used in such an unconventional manner.

With more than a million pools in the nation's backyards, with annual deaths in the hundreds and annual injuries in the thousands, questions of legal liability have gained fresh importance.

By and large, the pool owner is not liable for a mishap which he could not reasonably have foreseen or prevented.

Many communities, however, have increased an owner's responsibility by special ordinance—notably, by requiring pools to be fenced. Furthermore, he may become liable on grounds of simple carelessness.

Another case involved the drowning of a neighbor's child in an untended pool. Although the pool was properly fenced, the owner had left the gate open and a gurgling hose running into the water.

In these circumstances, a court said the owner could be blamed for having set the stage for tragedy.

One neighbor, irked by the lights and noise from a new pool next door, called it a "nuisance" and sued for an abatement order. But the court, after hearing from other neighbors and finding them unruffled, decided that the lights and noise were within lawful limits.

"Not every inconvenience," said the judge, "will call forth the restraining power of a court."

A public service feature of the American Bar Association and the Indiana State Bar Association. Written by Will Bernard.

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SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 46208

Please send me an application form for a scientific exhibit at the ISMA Annual Convention, Oct. 9-12, 1976, at Indianapolis

I propose to exhibit _____

Name _____

Address _____

City, State and ZIP _____

Because of limited space the committee has set a limitation on scientific exhibits. Consequently, the committee will allocate space on a priority based on date of receipt of the application.

Deaths

Arnold Brockmole, M.D.

Dr. Arnold W. Brockmole, Evansville, director of the city-county health department since 1960, died in a St. Louis hospital Apr. 15. He was 59.

An obstetrician-gynecologist, Dr. Brockmole entered the public health field after suffering a heart attack 20 years ago.

A graduate of the St. Louis University School of Medicine, he interned at St. Luke's Hospital, Cleveland. Dr. Brockmole was a member of the State Health Facilities Council, which licenses all nursing homes in Indiana, and was a past president of the Indiana Public Health Association, which honored him in 1966 with its distinguished honor award for outstanding achievement in public health.

He served as vice chairman and later as chairman of the ISMA Section on Public Health for many years. He was a member of the Vanderburgh County Medical Society and the American Medical Association.

Ira Cole, M.D.

Dr. Ira Cole, Lafayette obstetrician, died Apr. 21 in Home Hospital. He was 85. He had practiced medicine for 50 years in Linden, New Richmond and Lafayette.

A graduate of the Indiana University School of Medicine, Dr. Cole interned at the former Protestant Deaconess Hospital, Indianapolis, and was an Army veteran of World War I.

He was elected to Fellowship in the American Academy of Obstetrics and Gynecology and the Indiana Chapter of the International College of Surgeons. He served as president of the staffs of both St. Elizabeth and Home Hospitals and as president of the Tippecanoe County Medical Association. A senior member of the Indiana State Medical Association and the American Medical Association, he became a member of the Fifty-Year Club in 1971.

Dwight DeWees, M.D.

Dr. Dwight L. DeWees, 74, who retired in 1967 after 36 years of practice as a physician, died Mar. 15 at home.

He was a 1929 graduate of the Indiana University School of Medicine and served his internship and residency at the former Coleman Hospital at the Indiana University Medical Center.

A former member of the staffs of the Indiana University Medical Center, Methodist and Community Hospitals, Dr. DeWees was also a member of the American Medical Association and the Marion County Medical Society.

In 1972 he became a senior member of the Indiana State Medical Association.

Richard W. Emme, M.D.

Dr. Richard W. Emme, Harlan, a charter Fellow in the American Academy of Family Physicians, died at home Apr. 25. He was 61.

Upon his graduation from the Indiana University School of Medicine in 1938, he interned at St. Vincent Hospital, Indianapolis, and then returned to practice in Harlan.

During World War II he served with the United States Army Air Force and was discharged with the rank of Major.

Dr. Emme was on the staff of the Lutheran and Parkview hospitals in Fort Wayne and was a member of the Allen-Fort Wayne Medical Society and the American Medical Association.

Robert E. Hill, M.D.

Dr. Robert E. Hill, 71, Yorktown, died May 14 at Woodland Nursing Home, Muncie.

He practiced dentistry for two years in Muncie following his graduation from the Indiana University School of Dentistry. He then returned to the university to obtain a degree in medicine and practiced in Muncie with his father, Dr. Frank E. Hill, until entering service in World War II and serving in Burma.

Following discharge from the service Dr. Hill continued his medical practice in Muncie for about two years before moving to Yorktown,where he practiced for 19 years before his retirement.

A senior member of the Indiana State Medical Association, he was also a member of the American Medical Association and the Delaware-Blackford County Medical Society.

R. L. Kleindorfer, M.D.

Dr. Roscoe Kleindorfer, 77, retired Evansville surgeon, died Apr. 11 at Deaconess Hospital.

A past president of the hospital's medical staff, Dr. Kleindorfer was also a past president of the Vanderburgh County Medical Society. Before moving to Evansville, he practiced in Washington for 11 years and served as president of the Daviess-Martin County Medical Society in 1934.

Dr. Kleindorfer graduated from the Indiana University School of Medicine in 1924 and served his internship at St. Vincent Hospital, Indianapolis.

A veteran of both world wars, he served with the surgical department of the technical school in Springfield, Mo., during World War. II.

A Fellow of the International College of Surgeons, Dr. Kleindorfer was also a member of the American Medical Association, became a senior member of the Indiana State Medical Association 1970 and a member of the Fifty-Year Club in 1974. He also served on the Commission on Public Information for a number of years.

Albert E. Stouder, M.D.

Dr. Albert E. Stouder, Kempton, died Mar. 1 in Methodist Hospital, Indianapolis. He was 64.

Dr. Stouder began his medical practice in Kempton in 1936, following his graduation from the Indiana University School of Medicine and internship at the university medical center hospitals. He retired in 1974.

A member of the Tipton County Medical Society, Dr. Stouder had served as delegate and alternate delegate for many years, also as secretary, treasurer and vice-president of the county society. He was also a member of the American Medical Association.

Ralph W. Taraba, M.D.

Dr. Ralph Waldo Taraba, Bloomington, a physician for the Social Security Administration in Indianapolis for the last six years, died Apr. 1 in his home. He was 59.

He formerly was a member of the medical staff at the Veterans Administration Hospital at Danville, Ill., and had been a physician at the Indiana University Student Health Center for four years.

Dr. Taraba was a graduate of the Northwestern University School of Medicine and had engaged in private practice in the Chicago area.

He was a member of the Owen-Monroe County Medical Society and the American Medical Association.

COMMERCIAL ANNOUNCEMENTS

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EMERGENCY DIRECTOR for Michigan City, Ind., hospital. Competitive remuneration; 40-50 hours per week; malpractice insurance paid. Contact AMESCO, 606 Wilshire Blvd., Santa Monica, Calif. 90401; telephone 213-451-5481.

PHYSICIAN OPENING IN INDIANA REHABILITATION SERVICES INDIANA REHABILITATION SERVICES has openings for physicians in its various divisions. Interested persons should contact Dr. Walter E. Deacon, #1016 Illinois Building, 17 West Market Street, Indianapolis, Indiana, Telephone: 317-633-5961.

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Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

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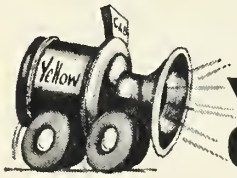
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The JOURNAL

OF THE INDIANA STATE MEDICAL ASSOCIATION

August 1976
Vol. 69 · No. 8
Indianapolis



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Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

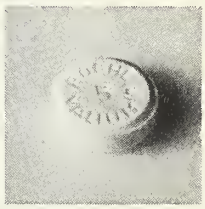
Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

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Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MEDICAL MUSEUM NOTES



The Summer and Fall issues of the *Indiana Medical History Quarterly** will be primarily concerned with medical colleges at Fort Wayne. Dr. Edmund L. VanBuskirk of Lafayette, whose father and great-uncle served on the faculties of these schools, has provided the manuscript and numerous illustrations.

The Indiana Medical History Museum now has an oil painting of this school (thanks to the voluntary contributions of those ISMA members supporting this project) and this will be reproduced in color on the cover of the Summer issue.

The painting is by Harry Davis, who has been commissioned to paint the various medical schools associated with Indiana's early history of medical education.

An exhibit of Harry Davis' paintings was featured in the show windows of L. S. Ayres & Co. during the week of the Memorial Day Holiday. The Medical History Museum's painting of the Central College of Physicians and Surgeons was loaned for the occasion.

The Amphitheater of the old Pathology Building provides the permanent gallery for exhibiting these medical school paintings. The Amphitheater is being developed so as to display the history of medical education in Indiana. In addition to paintings, the Museum is seeking diplomas, matriculation tickets, graduation announcements, photographs and other memorabilia pertaining to the education of Indiana's physicians. The material need not be restricted to Indiana's schools.

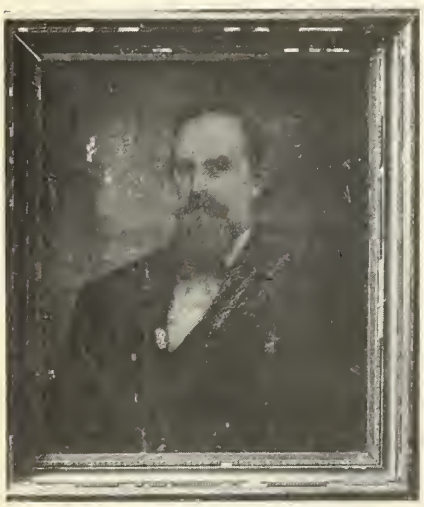
Indiana University School of Medicine has contributed to this endeavor by providing portraits (some by T. C. Steele) of men associated with these early schools. Included among these are portraits of Dr. John Bobbs and Dr. William B. Fletcher, both of whom were founders of the 1869 Indiana Medical College.

Contributions are also coming from private sources. The descendants of Dr. Benjamin Newland of Lawrence County, for example, have given his portrait done from life in 1877 by G. W. Morrison. As a youth Ben Newland carried mail on horseback between Orleans and Indianapolis, and between Bedford and Versailles. He was a Brigadier General in the State Militia during the 1850s, and was in charge of a large Military Hospital in Missouri during the Civil War. In 1879 he served as president of the Indiana State Medical Association. Dr. Newland was a large man. He weighed 250 pounds, and stood well over six feet. The painting conveys this impressive physique by means of an unusual perspective.

Another unusual portrait, one which prompts the present article, is one which we hope the readers of this page can identify. This particular portrait is of one of the teachers associated with a medical college at Fort Wayne—but which one? The painting, which is not dated, was done by George W. White of Hamilton, Ohio. The illustration on the right shows the painting as originally received at the Museum. The center illustration shows the portrait's present condition. It was cleaned, repaired and restored by William G. Ashby of Indianapolis. Who can provide the man's identity? Can you?

CHARLES A. BONSETT, M.D.
6133 East 54th Place
Indianapolis 46226

*Published by the Indiana Historical Society, 140 N. Senate Ave., Indianapolis 46204.



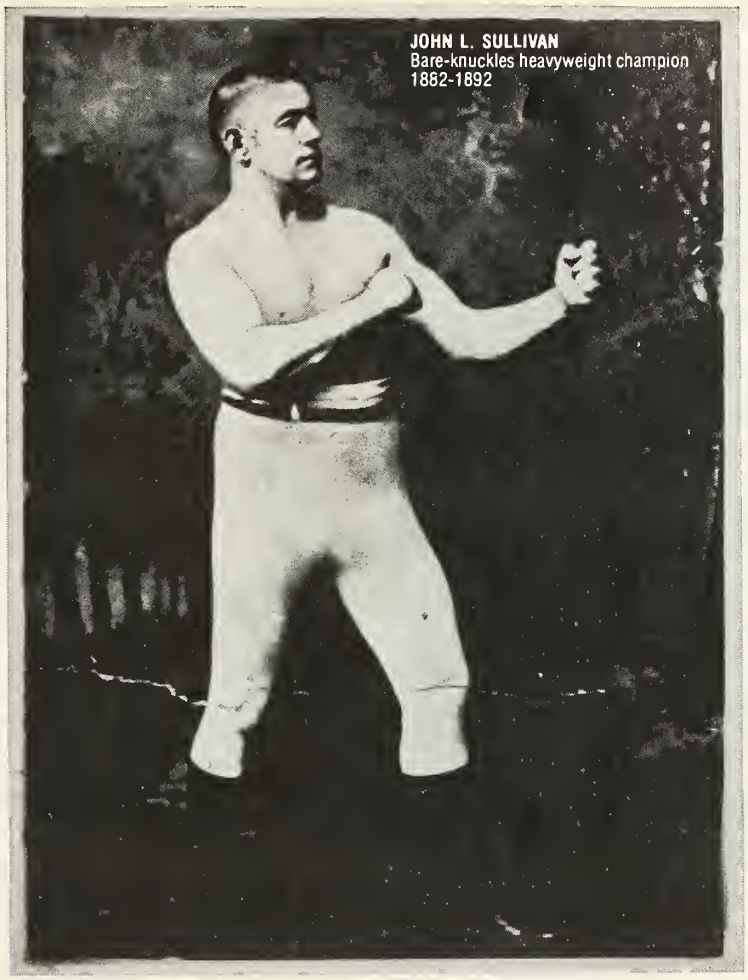
BENJAMIN NEWLAND, M.D.
Lawrence County





"BEFORE AND AFTER" views of portrait of Fort Wayne Medical School teacher whose identity is being sought.

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Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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AUGUST 1976

The Journal
of the INDIANA STATE MEDICAL ASSOCIATION

Office of Publication
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Photographs should be printed an glassy paper. Negatives cannot be used.

Illustratians are desirable. Selection of illustrations submitted at discretion of editor and editorial board members.

Contributors are responsible for all statements made in their articles. The editors and editorial baard members may not be In agreement with all views expressed by authors, but it is desired to give all authors as great latitude as possible.

Articles are accepted far publicatian with the understanding that they are submitted for exclusive publication.

Communications dealing with editorial matter should be sent to Frank B. Ramsey, M.D., Editor, 3935 N. Meridian St., Indianapolis 46208. All other communications shauld be sent to THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian, Indianapolis 46208.

Advertising rates will be furnished on request. Copy must be received by the 1st of the month preceding month af issue. (Scientific manuscripts must be received at least twa weeks earlier if geared far a specific issue.)

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Our Internatianal Standard Serial Number is ISSN 0019-6770.

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OCTOBER 16th IS THE DATE!

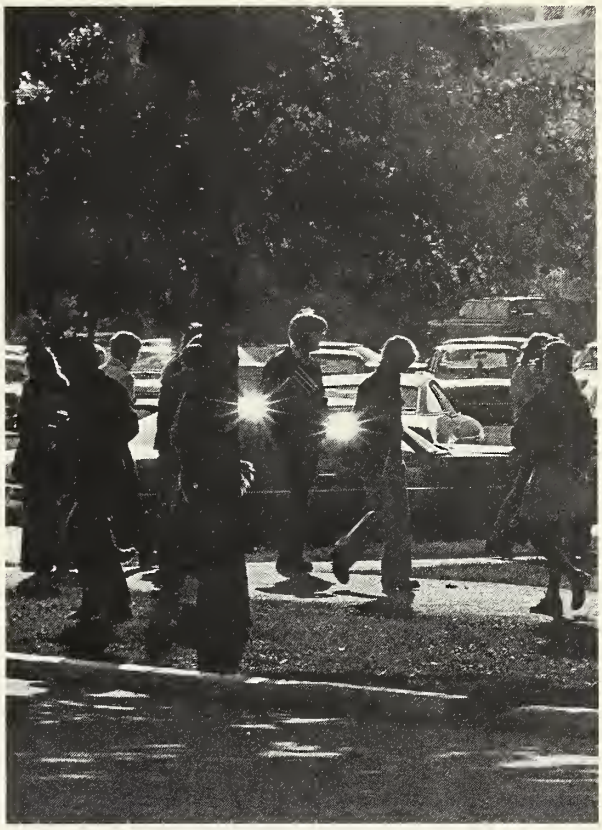
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TO: HIGH SCHOOL DAY, BUTLER UNIVERSITY

Please reserve _____ places (for me _____ my parents _____) for Butler's HIGH SCHOOL DAY on Saturday, October 16, 1976. I (we) will pick up registration materials by 8:30 a.m. (E.S.T.) in Clowes Memorial Hall on the University campus.

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() Please find check enclosed for _____ luncheon reservations at $2.25 each.

() I (we) will not be remaining for lunch.

STUDENT'S NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP _____

Year in High School _____ Intended College major _____ Sex _____

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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

CONGRESS IS EXPECTED SHORTLY TO PASS legislation that it hopes will bring aid to a foundering Health Maintenance Organization (HMO) program.

The Senate has easily approved (80-8) a measure similar to one adopted by the House last fall authorizing $250 million over five years for HMOs and relaxing or removing many current federal restrictions.

The snail's pace growth of HMOs, a specific type of prepaid group practice organization, since the original HMO bill was approved three years ago, prompted the present Congress to liberalize the program in hopes the concept might move more quickly.

The most controversial feature of the measure in Senate debate was elimination of the open enrollment requirement for most HMOs. Chief Senate HMO champion, Sen. Edward Kennedy (D-Mass.), felt so strongly about this provision, also in the House bill, that he voted against the bill on the final tally.

Kennedy told the Senate that dropping open enrollment "represents a giant step backward in terms of public policy and has once again resulted in an abdication of the Congressional responsibility to extend the benefits of public programs to those least able to personally confront the members of Congress or their staffs in the same way that the commercial HMO and insurance organizations have been able to."

Proponents of the provision argued that it was needed in order to allow HMOs to be able to compete with other types of health insurance.

The American Medical Association, in testimony before House and Senate, asserted that the open enrollment requirement had been one of the prime justifications for enacting the HMO bill in the first place.

This provision, and some others, served to narrow the legislation to almost a simple subsidy of existing prepaid group practice plans, the AMA testified.

When Kennedy and others talk about restructuring the present health system, the main object they have in mind is making HMOs the dominant form of health care delivery, with physicians as employees of the HMOs paid by salary rather than fee-for-service. Despite the importance of the bill, the debate was brief and desultory, except for Kennedy's strong complaint about open enrollment.

In order to attract more physicians to HMOs, the bill would allow physicians to devote as little as 35% of their practice to HMOs and still be members of the HMO group. Current law requires more than 50% of professional time.

Under the Senate bill, community rating of charges for new HMOs would be delayed for three years compared with five

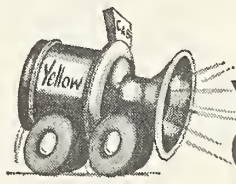
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years in the House bill. The Senate version provided that existing HMOs with more than 50,000 members would have to enroll at least four percent of new subscribers as open enrollees.

Some major required basic benefits were excluded, but the Senate retained alcohol and drug abuse treatment and home health services as basic benefits that must be offered. The House had shifted these to the optional, supplemental category.

The Senate bill did not touch on the dual option provision approved by the House, leaving the way clear for this to be enacted. The original HMO bill required employers to give their employees a choice between standard health insurance and a qualified HMO. The so-called "dual option" encountered trouble with labor laws covering collective bargaining rights. As a result, the House gave labor at collective bargaining the right to choose a standard health insurance plan as the exclusive plan for union members without a worker's option to select an HMO. But the bill does not permit the reverse, selection of an HMO by labor to the exclusion of a standard plan. Among other reasons for retaining the option in this case is the legal question involved in the federal subsidization of the HMO as opposed to the non-subsidized standard health insurance package.

FORMER GEORGIA GOV. JIMMY CARTER will send Congress a proposed national health insurance program right off the bat if he becomes President.

The apparent Democratic presidential nominee told reporters "I'm not going to wait . . . on welfare reform, national health insurance, etc. I intend to be ready to go with that the first of the year."

In social programs, former President Lyndon Johnson "did an excellent job, but we still have a long way to go with national health care, reform of the welfare system, reform of the tax system," said Carter. "I don't make those commitments idly," he said. "This is something that should be done. I say that we need a national health insurance program—I mean to do it."

THE DEMOCRATIC PLATFORM COMMITTEE recommended a comprehensive national health insurance plank for the party's presidential convention in July. The recommended health plank endorsed no specific measure, a blow to labor's hopes for unqualified backing of the Kennedy-Corman NHI plan. A convention floor fight is unlikely.

The committee voted a statement on health that says NHI "should be financed by a combination of methods that will be adequate but not impose new or undue burdens. Consideration should be given to developing a means of support for NHI that taxes all forms of economic income."

The 153-member committee took a partisan slap at the Ford Administration declaring "an increasing Republican emphasis on restricting eligibility and services is emasculating basic medical care for older citizens who cannot meet the rising costs of good health."

Though calling for universal and mandatory coverage, the health plank said "national priorities of need and feasibility should determine the stages of the system's implementation. We must achieve all that is practical while we strive for what is ideal, taking intelligent steps to make adequate health services a right for all our people."

Maximum personal interrelationships between patients and their physicians should be preserved, the proposal said. "We should build on existing structures and experiment with new forms of medical care delivery to mold a national health policy that will meet our needs in a fiscally responsible manner."

EARLIER, THE AMA HAD TOLD THE DEMOCRATIC CONVENTION Platform Committee that health care would come out second best in the scramble for federal dollars if a new Congress enacted proposals to restructure the entire health system.

A MAJORITY OF ADULT AMERICANS SUPPORT a ban on cigarette advertising, according to a survey by the National Cancer Institute and the Center for Disease Control.

THE WHITE HOUSE COUNCIL on Wage and Price Stability has scheduled hearings in New York, Chicago and San Francisco this summer on rising health care costs and what can be done about them. Though legislation is needed to allow the Council to get back into the business of freezing wages and charges, the Council can make recommendations to the President and Congress on possible solutions. The American Medical Association is expected to testify at the New York hearing.

THE JUSTICE DEPARTMENT IS STUDYING the entire health field for possible anti-competitive aspects, according to Assistant Attorney General Thomas Kauper.

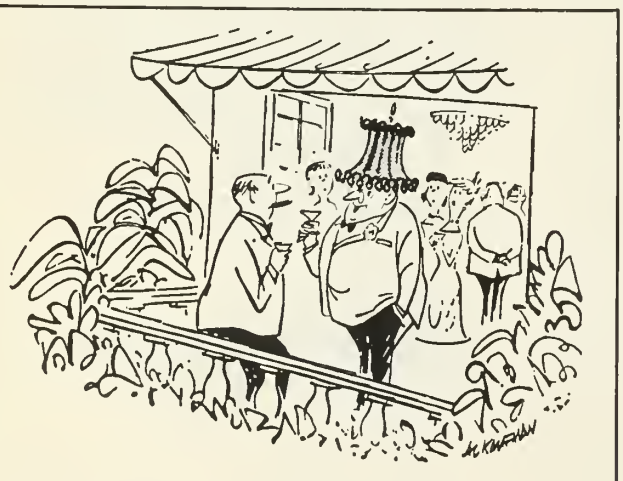
Kauper, head of the Justice Department's antitrust division, conceded that how anti-monopoly statutes apply to health "is a hard question to answer." At a farewell news conference, Kauper, who is leaving government, noted that most hospitals are non-profit and aren't engaged in competition with other hospitals. He said many hospitals "suggest they're not even a business" and therefore are not subject to antitrust laws.

The Justice Department and the Federal Trade Commission have stepped up their antitrust actions in health matters in the past year. Justice has filed a price-fixing complaint against the American Society of Anesthesiologists. The FTC, which earlier announced its own broad probe of health, has filed suits agains the AMA for ethical prohibitions against advertising, against Blue Shield plans for possible antitrust violations due to alleged physician control, and has changed commercial restrictions in the prescription eyeglass industry.

FTC and Justice have partially overlapping jurisdictions in the antitrust area, and long rivalry exists between the two agencies.

Some dichotomies mark the antitrust units' interest in health. Critics of the U.S. system often characterize it as "a cottage industry," the antithesis of a monopoly. And the HEW Department exerts pressures on the system for uniformity and standardization that in the normal market place would be considered anti-competitive.

Antitrust officials at Justice stress that no imminent legal action is on the horizon; that the health field is simply being studied at present. ◄



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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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History of Early Anesthesia in Indiana
(Part Two)

GEORGE M. ROSENHEIMER, M.D.
South Bend

ON September 1, 1947, a Department of Anesthesiology was established at the Indiana University School of Medicine in Indianapolis. Dr. Virgil K. Stoelting was appointed chairman and assistant professor of anesthesiology in the School of Medicine. This was one of the very earliest departments of Anesthesiology of a medical school in the United States, those at the New York City Medical School (1932) and the University of Wisconsin (1927) being the first. Dr. Rovenstine and I had tried to persuade Dr. Gatch (then dean of the Medical School) to establish such a department in the early 30s. Mr. Ball of Muncie had given the Medical School some money for anesthesia. Dr. Gatch stated that Dr. Maxine Gibson was doing a fine job at the Medical Center, giving ether and nitrous oxide-oxygen-ether anesthetics, and he saw no need for a Department of Anesthesia. It was not until Dr. John Van Nuys became dean of the medical school that the Trustees of Indiana University were asked to establish a Department of Anesthesiology on the Indianapolis campus. He obtained this in 1947 and it was with the backing of the physician anesthetists of Indiana.

Dr. Stoelting has done a splendid job and is still doing so. Some of his earlier residents were: Drs. Guy Morford (1928), George Rasch (1949), Zairo Vieira and Ike Craig (1948). Dr. John Graf joined the department as assistant professor of Anesthesiology, followed by Drs. Joseph Nordurf (1949), Richard Theye, John Krueger, Paul Littlefield, Frank McKechnie (1950), June Dvorak (1951), Drs. George Parker of Linton, Virginia Bond, Jane Jameson, Donald Spahr and Phillip Ramer (1952), Drs. Charles Dreher, Robert Vore, H. Dagley, Robert Bush and many more since that time.

Most of the anesthetics given early in Indiana were given by the referring physician to the surgeon; or sometimes by one physician more skilled in anesthesia than others, or by nurses. These nurses were trained from short courses to six months training in anesthesia, and were either hired on a salary by the hospitals or privately hired by a surgeon to do his anesthetics. The anesthetics were mostly open-drop ether; occasionally chloroform; later, nitrous oxide-oxygen-ether anesthetics. After cocaine, and then novocaine, were discovered, many operations were done under local infiltration and blocks, such as hernias, appendectomies, thyroidectomies, and several other procedures. Many of these early physicians became very skilled and were called upon to do the more serious operative anesthetics. There were many over the state of whom I have no information, but I will try to name some by the area in which they practiced.

Vincennes was one of the first settlements in Indiana. Good Samaritan Hospital had three nurses who were employed by the hospital. There were no physician anesthetists until Dr. Richard H. Stein arrived in 1957 for the private practice of anesthesiology on a fee-for-service basis. In 1959 he was joined by Dr. Charles Klein, and in 1961 by Dr. Harry Parmenter, and later, in 1964, by Dr. Charles Miller.

Evansville. Dr. John H. Combs came in 1934 to the Welborn Hospital. Drs. Clarence Baker and Joseph Weis were giving anesthetics there at that time, and helped him in his early endeavors in anesthesia. Dr. Margaret Tilden also was there (she is now at the Deaconess Hospital), also Dr. Grace Coffman (1934) and two other women physicians, Drs. Grace Hawthorne and Marian Morgan. Prior to 1934, Dr. Dalton Wilson had been practicing anesthesia. He was killed in an explosion of a gas—probably ethylene—but not during the giving of an anesthetic, thus no patient was in-

Part One of this two-part article appeared in our July issue.



Charles Cabalzer, M.D.

volved. In 1949, Dr. Richard H. Russell arrived from Indianapolis City Hospital, where he had trained under Dr. Lillian Mueller. He was followed shortly by Dr. Julius Pastor.

Jeffersonville. Dr. Ernest P. Buckley began anesthesia early in the 30s, and we attended together many of the early annual meetings of the International Anesthesia Research Society.

Portland. Dr. Donald E. Spahr (1947-1970), retired; took his residency at the Indiana Medical Center.

Richmond. Dr. Gayle J. Hunt was giving anesthetics there in the early 30s.

Franklin. Dr. Walter Portteus, a past-president of the Indiana State Medical Association, a general practitioner, gave anesthetics there. Dr. Frances Jones came in 1945.

Muncie. Before 1929 a number of general practitioners gave the anesthetics at the Home and Dr. Mix's Hospital. About 1905 Dr. Clay H. Ball joined Dr. Mix. Ball Memorial Hospital opened in 1929, and Dr. Robert Cole and Eugene Eissman (he had several years of medical school, but never received his diploma) gave anesthetics and also did the laboratory work for the hospital. In 1942 Dr. William B. Adams came to Ball Memorial Hospital. Dr. Margaret Benjamin (1935-41) had preceded Dr. Adams. She was assisted by several nurse anesthetists.

Marion. Early anesthesia was given by two physicians, Drs. Max Ganz and John Rhorer, and four nurse anesthetists. They gave for OBs and surgery. These were hired by the hospital, which has five nurses now. Dr. M. Arthur Grant started part time in anesthesia there in 1952, and full time in 1963.

LaPorte. Dr. E. A. Rovenstine started giving anesthetics as a general practitioner in 1928-1929. He then left to take a residency in anesthesiology at the University of Wisconsin under Dr. Ralph Waters. Dr. Robert M. Kelsey, a general practitioner, gave anesthetics there in the early 30s, especially for Dr. Jones of LaPorte—until his recent death.

Kokomo. Many G.P.s gave the anesthetics here before Dr. Guy Morford came in 1950. In 1951, Dr. Carl H. Ault came to Kokomo; Dr. Robert Phares was also giving anesthetics. In one year, Dr. Ault personally gave 1,810 anesthetics.

Crawfordsville. Dr. John L. Sharp gave anesthetics there until his death in 1961.

Anderson. Dr. Reuben Zierer started in anesthesia here in the early 1930s; also Dr. William K. Patterson, who is still active. Dr. Joseph H. Stamper came in 1946, after leaving the Navy. Also, a Dr. Charles (a woman) gave some anesthetics.

Bloomington. Dr. Naomi L. Dalton was active here.

Carmel. Dr. Claud M. Donahue worked principally at the Noblesville Hospital.

Elkhart. Before 1926, Dr. Sam Wagner was active in anesthesia. Dr. Arthur Hull started in 1925. (He had a gas machine at that time.) He and I made many trips to see Dr. Ralph Waters at Madison, Wis., to observe and get advice when we needed it. Dr. George Paine came to Elkhart in 1948. Dr. Hull told him at that time "to watch the veins in the back of the hand of patients; if they began to collapse, better do something at once." Twenty years later, central venous pressure was brought to our attention.

Rensselaer. Dr. Harvey E. English, who was a general practitioner, gave the anesthetics here from about 1921 until his death.

Logansport. Dr. Earl Palmer probably gave most of the anesthetics here from 1920 to 1946. Marian Hochhalter, M.D., did a lion's share from 1925-1950, and introduced Avertin and then Cyclopropane here. Dr. Lowell Hillis did anesthesia from 1940 to 1955. Dr. Donald Winter started in 1946 and retired in 1969. Drs. J. Carl Jones and Russell J. Morrical began giving anesthetics about 1950 and are doing most of them now.

New Castle. Dr. Alexander F. Craig came from a residency at Indiana University Medical Center and did full-time anesthesia. He left in 1964 to practice in Indianapolis.

Terre Haute. Dr. Charles Combs was administrator of the Union Hospital (1910-1941), and medical director (1941-1948), but he did anesthesia in his medical time off (mornings). A president of the Indiana State Medical Association, he was active in anesthesia from 1907 to 1957, and died in 1960. Dr. E. T. Zaring did part time anesthesia in the early 30s; Dr. Charles Ragin did full time anesthesia. Dr. Glen G. Musselman came in 1936, then limited his practice to anesthesia in 1943. In 1944 Dr. J. M. Sullivan joined him, doing part time anes-



Virgil K. Stoelting, M.D.

thesia. In 1946, Dr. Annie L. Millas joined the group full time until her death.

Gary - Munster - Hammond - East Chicago Area. Anesthetics were given at the various hospitals by staff members. Dr. Paul Yocum, Sr., a surgeon, gave his own spinal anesthetics and also gave open-drop ether for some of the other surgeons. Dr. Kudel gave anesthetics at St. Mary's Hospital, and worked for the hospital. Dr. Burnell Fisher was at Methodist Hospital, but now is at St. Margaret's Hospital in Hammond. There was a woman physician who left before 1948. Dr. Neal Davis joined Dr. Dorothy Darling in 1952. She came to Gary in 1948 from a residency at Columbia Presbyterian University, New York. Drs. Adolph Walker and Louis Teplinsky went to East Chicago to do full time anesthesia in 1950. Dr. Russell Kretsch was in general practice but did anesthesia in Hammond in 1930s and 1940s.

Fort Wayne. Physicians in general practice gave a large portion of the anesthetics, mostly for each other. However, four or five did a large part of the work. There were a few nurses employed by the St. Joseph and Lutheran Hospitals and one or two were employed by the surgeons themselves to give anesthetics. Dr. "Red" Richardson came to Ft. Wayne in the early 1930s. He charged $25.00 for a TUR, and was told "by all" that the fee was "too high." After six months, he became discouraged and left for New England, where he made good. Drs. Emery Hamilton and Russell E. Havens came in 1947 and did full time anesthesia. Dr. Eugene Schmidt joined them later. Dr. William Clark (a general practitioner) did early anesthesia here; during World War II, he trained many G.I.s in anesthesia. He did the first spinal puncture, the first closed anesthesia (using a Ben Morgan Machine, along with self-designed nasal and tracheal tubes), the first I.V. anesthetic using pentothal sodium, and was one of the few to be allowed to use chloroform. Dr. Richard A. Theye joined the group; he later left to join the Mayo Foundation. In 1951, Drs. Dick Johnson, John Jackson and Herbert Spencer came to town to do full time anesthesia.



Roy A. Geider, M.D.

Lafayette. Dr. Floyd T. Romberger came to Lafayette in September 1920, limiting his practice to anesthesia until his death in 1954. He became president of the Indiana State Medical Association and was the first chairman of our state Section on Anesthesia. Dr. Frank W. Ratcliff joined him in 1929. Dr. William Sholty limited his practice to anesthesia and joined the group in 1948. Dr. Robert W. Vermilya joined them in 1949; Dr. Harley H. Frey came in 1950. Dr. Mary K. Ade does general practice but also has done anesthesia since 1943. Several other full time anesthesiologists have come to Lafayette in recent years.

South Bend. Many of the referring physicians gave the anesthetics here, but one general practitioner, Dr. Harry Mitchell, a Canadian who came to South Bend in 1894, gave one of the best ether anesthetics I ever saw. In 1924 there was a nurse anesthetist at St. Joseph and Epworth hospitals (the latter is now Memorial Hospital), and another was hired by the South Bend Clinic for its surgeons. These were paid salaries by their respective employers. I started giving anesthetics when I interned at Epworth Hospital in 1924. The nurse anesthetist taught me what she knew. I gave OB anesthetics and some ether, and chloroform for minor procedures, and later learned to give ethylene and oxygen-ether for surgery. In 1931, I limited my practice to anesthesia.



Fred Thomas, M.D.

In 1934, I was asked to form and direct the Department of Anesthesia at Epworth Hospital. I was assisted by two general practitioners, Dr. L. L. Frank, Sr., and D. W. Frash, Sr. In 1939, we were granted a residency in anesthesiology and trained several residents. The first was Dr. Edson Fish (1939-1941), who left to form the Anesthesia Department at St. Joseph Hospital in 1941.

Dr. Paul Haley, a general practitioner, gave anesthetics from 1934-1938 at St. Joseph Hospital, with Dr. Harold Rodin and Dr. Lillian Holdeman (1934-1936); Drs. Josephine Murphy and Ben Firestein worked there from 1938 to 1941. In 1938, Dr. Merle Liston, a resident from Methodist Hospital, Indianapolis, came to St. Joseph Hospital and formed the Anesthetic Department. He, however, quit anesthesia in 1941 to do general practice. Dr. Edson Fish then took charge at St. Joseph Hospital; he was joined in 1951 by Dr. John Krueger; in 1953 by Dr. John Graf; Dr. John Karn, part time from 1944 to 1950, and full time in 1950. Later (1957), Dr. Ed Walker

joined the group; in 1945-1947 Dr. Edward Rustin joined Dr. Fish; Dr. Dave Parkes worked with Dr. Fish in 1947-1951, then he moved to Wyoming to do anesthesia.

Dr. Ames Templeton came to Mishawaka's St. Joseph Hospital full time in 1949. Before that time, Dr. Francis Logan (1925-1935) and Dr. Wendell Spaulding (1930-1949) gave anesthetics at that Hospital.

Dr. Bernard Edwards (a general practitioner) gave most of the anesthetics at our Crippled Children's Hospital during World War II and now is doing full time anesthesia at St. Joseph's Hospital.

Indianapolis. Indiana University Medical Center: Dr. Arthur Guedel gave lectures on Anesthesia to the junior class each year, giving six to eight lectures. He started before 1924, because he taught our Class of 1924. He left the department after difficulties with the dean of the Medical School, Dr. Gatch. Dr. Charles Cabalzer gave most of the anesthetics for Dr. John Barnhill's operations of the head and neck. He gave the first intro-tracheal anesthetic I ever saw in 1923. An elderly male, with carcinoma of the tongue, was given nitrous oxide-oxygen-ether anesthetic by Dr. Cabalzer, then Dr. Barnhill did a tracheotomy and placed a large red rubber catheter in the opening, sealing it off with gauze and tape, then Dr. Cabalzer continued the anesthetic, which lasted two or three hours. The patient recovered and left the hospital.

Dr. Harold Trusler (a general surgeon) assumed the role of teaching anesthesia to the students after Dr. Guedel's departure, until 1945. He became interested in plastic surgery and was well-known in this field. In 1945 Dr. Roy Geider was enticed to come back and be in charge of anesthesia. Dr. Greta Maxine Gibson was an Indiana graduate who interned at the Center and stayed on in anesthesia, teaching the interns the specialty and doing much of the anesthesia work for Drs. Gatch and John Owens. She resigned her position in 1948, and joined the anesthesia staff at Methodist Hospital; she is now retired.

Dr. Roy Geider was head of the Anesthesia Department from 1945 until Sept. 1, 1947, then continued to give anesthetics for an additional two years until 1949. He is still active.

The first resident appointment at the Medical Center was February 1, 1948, and was Dr. Guy Morford, now of Bloomington, followed in July by Drs. George Rasch, Zairo Vieira, and Ike Craig. In August 1948 Dr. John Graf joined the department as assistant professor, he had previously trained at Veterans' Hospital, under Dr. Lillian Mueller, who was in charge of anesthesiology at Marion County General Hospital and the Veterans Administration Hospital. Dr. Graf remained until 1935, when he entered the private practice of anesthesia at South Bend. In August 1949 Drs. Joseph Nordurf, Richard Theye, John Krueger, Paul Littlefield and Frank McKechnie were added. Each year, a large number of residents have entered training.

St. Vincent Hospital. Probably the earliest anesthetists at St. Vincent Hospital were Dr. Karl Ruddell, well-known surgeon of Indianapolis today, and Dr. Arthur Guedel. In 1924, Dr. Guedel was in charge of the anesthetic department, giving lectures to the interns and residents. Dr. Guedel left St. Vincent to go to Los Angeles about 1928. Dr. Fred Thomas, who interned there and remained as house physician, gave anesthetics in the mornings. He went into general practice in 1927 in Indianapolis, but took over as head of the Anesthesia Department on Dr. Guedel's departure. He retired December 31, 1970. Other physicians giving anesthetics here were: Dr. Maurice V. Kaylor (full time, 1920-1922), and part time (1923-1924), then he went into private practice; Henry Nolting (1923-1924), Paul Furgason (deceased), Daniel McDevitt (deceased), Alan Sparks (1925-1926), Bernard J. Mathews (deceased), Joe Shugart (now in Texas), George T. Paulissen (deceased); in 1956, B. C. Gardner, Leo Bartle, Lillian Mueller (deceased), M. J. VanDorn. Dr. Willis W. Stogsdill is the present head of anesthesia here.



Joseph T.C. McCallum, M.D.

St. Francis Hospital — Beech Grove. Dr. Bernard J. Matthews, now deceased, came to Beech Grove in 1932 to administer anesthetics and remained until he retired in 1970. Dr. George T. Paulissen joined him about 1950 and remained until his recent death.

City Hospital of Indianapolis. Most of the anesthetics given here were given by interns and medical students, who had to give six anesthetics before graduation. The junior intern on surgery was in charge of anesthetics, when I graduated in 1924. He allotted the patients to the medical students for anesthesia and was to supervise each one during the giving of the anesthetic. About 1925, Drs. William Ankenbrach and Paul Cullen assumed charge of the Anesthetic Department, instructing the interns and medical students. Dr. Charles Cabalzer gave most of Dr. John Barnhill's anesthetics in head and neck surgery. Dr. Arthur Guedel was also on the staff. In August 1939 Dr. William Adams became head of the Department of Anesthesia and remained until September 1940. He formerly was with Dr. Whitehead at the Methodist Hospital.

In 1940 the Department of Anesthesia was headed by Dr. Lillian Mueller, who had been assistant to

Dr. Whitehead at Methodist Hospital. She began an anesthesia residency. Among the first to finish their two-year residency was Dr. Richard Russell (of Evansville, now deceased). Dr. Mueller retired in 1955, and Dr. Robert Vore became the head of anesthesia, followed by Dr. Gale Dryden, who remained as chief until the management of the department was assumed by the Indiana University Medical Center. Dr. Virgil Stoelting is now the head of the department.

Dr. Joseph T. C. McCallum was active in anesthesia research at the hospital's Lilly Clinic.

Methodist Hospital. The first hospital anesthetist was Dr. Charles Cabalzer, probably before 1918. (There are no formal records of the Anesthesia Department at Methodist Hospital.) He was followed by Dr. Marie Kast. Dr. John M. Whitehead became head of the Department of Anesthesia about 1922. Dr. Cabalzer was a surgeon and Dr. Whitehead was in general practice, but gave his mornings to anesthesia.

There are two bronze plaques on the wall of the surgery area with the likenesses of Dr. Cabalzer and Dr. Whitehead. They are inscribed as follows:

"Charles L. Cabalzer, Physician, Teacher, Friend. Erected to his memory by the Staff Society of Methodist Hospital—1932."

"John M. Whitehead, Loyal, Faithful, Chief of Anesthesiology Department 1922-1953 — The Staff."

Dr. Lillian Mueller was on the hospital staff, first as a private anesthetist and later as a hospital employee. She was intimidated into joining the hospital staff by the business manager who told her to join the hospital staff or he "had an intern ready to take anesthesia training and he will take your place."



Marie Kast, M.D.

Arthur Guedel, M.D., did some work at Methodist until his departure for California.

Under Dr. Whitehead, the anesthesia department consisted of two residents, two interns, and six to eight part-time physicians working from eight in the morning until noon. Dr. Whitehead was also part time, and the chief resident was in charge of the department in the afternoon and evening.

During World War II, two nurses joined the anesthesia staff for the first time. Two trained nurse anesthetists, Regina Kirschner and Josephine Stout, were employed by the hospital, and also two general duty nurses were trained and employed by Dr. Whitehead—Fern Dumbauld and Beryl Newman.

Dr. Edward F. Bloemker joined the anesthesia staff in 1938.

Part time general practitioner anesthetists were: Drs. Glenn Ryan, Stanley Garner, Jason Weiss, Maurice Mentendiek, Ainsley Hood, Walter Tinsley, Phil Kurtz and Grover Bolling.

In 1947 Dr. Maxine Gibson resigned from the Indiana University Medical Center anesthesia staff to administer anesthetics for Dr. Gatch's patients at the Methodist. Dr. Whitehead had not permitted anyone on the staff for the private practice of anesthesia before this time.

In 1948 Drs. H. T. Moore and Pat Flanigan joined the anesthesia staff, full time and fee-for-service. In 1950 Dr. George Love joined the staff, followed in 1951 by Dr. Frank Cohn, then in 1954 by Dr. Paul Littlefield. By this time, private anesthesia was pretty well established.

I have attempted to produce some facts and reminiscences of interest of early anesthesia in Indiana, but there are probably mistakes and many omissions due to lack of data.

As you all know, many early operations were done in the homes on the kitchen table; anesthetics were given by the surgeons or another physician, or maybe by a member of the family itself. Also, the hospitals kept poor records or none at all of the operations and anesthetics done early in the hospitals. Then, too, the old records of nearly all the hospitals in Indiana are destroyed after 20 or 25 years.

I would like to thank all of you who have helped make this paper possible. If you know of or find any other pertinent material, please contact me and it will be greatly appreciated. ◄

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The AMA is being investigated to determine whether it "may have illegally restrained the supply of physicians and health care services," according to a Federal Trade Commission press release. AMA Executive Vice President James H. Sammons, MD, said: "We are frankly puzzled as to what precipitated the FTC investigation . . . We welcome an airing of the issue (because the investigation) is hard to square with the facts . . . We have not violated the antitrust laws. We have, as a matter of record, advocated increases in the numbers of physicians and health personnel."

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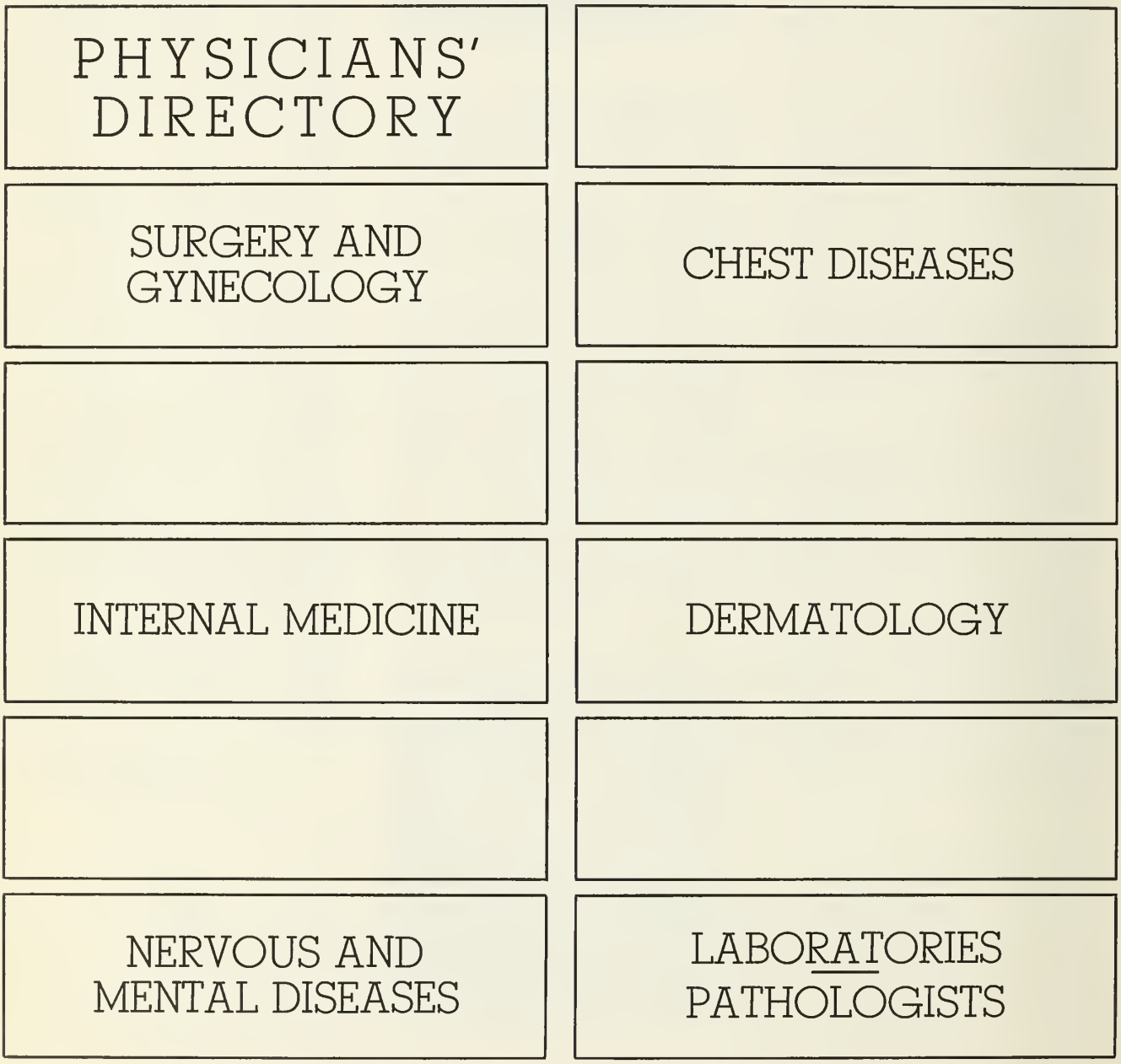
THE JOURNAL is resuming, on a trial basis, the publication of professional cards. This had been the custom for many years but was discontinued for a variety of reasons several years ago. It is now being reinstated as a service to physicians who are seeking clinical and laboratory consultants, and as a means by which readers may support *Journal* finances.

The cards will be printed in categories of specialties, as listed in the Annual Roster Issue. Admission to specialty classification will depend on certification by a national board of examination.

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Administration and Dosage: All efforts should be made to initiate therapy as soon as possible after the first symptoms of the attack are noted, since success is proportional to rapidity of treatment, and lower dosages will be effective. At the first sign of an attack, or to relieve the symptoms of the full-blown attack, one tablet is placed under the tongue. Another tablet should be taken at half-hourly intervals thereafter, if necessary, but dosage must not exceed three tablets in any 24-hour period. Limit dosage to not more than 10 mg. in any one week.

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Syphilis—CDC Recommended Treatment Schedules, 1976

THE following recommendations were established by the Venereal Disease Control Advisory Committee* after deliberation with therapy experts.**

Few data have been published on the treatment of syphilis since CDC revised these recommendations in 1968. Penicillin continues to be the drug of choice for all stages of syphilis. Every effort should be made to document penicillin allergy before choosing other antibiotics because these antibiotics have been studied less extensively than penicillin. Physicians are cautioned to use no less than the recommended dosages of antibiotics.

EARLY SYPHILIS (primary, secondary, latent syphilis of less than 1 year's duration)

(1) Benzathine penicillin G—2.4 million units total by intramuscular injection at a single session. *Benzathine penicillin G is the drug of choice because it provides effective treatment in a single visit.†*
OR

(2) Aqueous procaine penicillin G—4.8 million units total: 600,000 units by intramuscular injection daily for 8 days. **OR**

(3) Procaine penicillin G in oil with 2% aluminum monostearate (PAM)—4.8 million units total by intramuscular injection: 2.4 million units at first visit, and 1.2 million units at each of 2 subsequent visits 3 days apart. *Although PAM is used in other countries, it is no longer available in the United States.*

Patients who are allergic to penicillin:

(1) Tetracycline hydrochloride††—500 mg 4 times a day by mouth for 15 days. **OR**

(2) Erythromycin (stearate, ethylsuccinate or base)—500 mg 4 times a day by mouth for 15 days.

These antibiotics appear to be effective but have been evaluated less extensively than penicillin.

SYPHILIS OF MORE THAN 1 YEAR'S DURATION (latent syphilis of indeterminate or more than 1 year's duration, cardiovascular, late benign, neurosyphilis)

(1) Benzathine penicillin G—7.2 million units total: 2.4 million units by intramuscular injection weekly for 3 successive weeks. **OR**

(2) Aqueous procaine penicillin G—9.0 million units total: 600,000 units by intramuscular injection daily for 15 days.

The optimal treatment schedules for syphilis of greater than 1 year's duration have been less well established than schedules for early syphilis. In general, syphilis of longer duration requires higher-dose therapy. Although therapy is recommended for established cardiovascular syphilis, there is little evidence that antibiotics reverse the pathology associated with this disease.

Cerebrospinal fluid (CSF) examination is mandatory in patients with suspected, symptomatic neurosyphilis. This examination is also desirable in other patients with syphilis of greater than 1 year's duration to exclude asymptomatic neurosyphilis.

Published studies show that a total dose of 6.0-9.0 million units of penicillin G results in a satisfactory clinical response in approximately 90% of patients with neurosyphilis. There is more published clinical experience with short-acting penicillin preparations than with benzathine penicillin G. Some clinicians prefer

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**V Cave, M.D., Brooklyn, N.Y.; P.E. Dans, M.D., University of Colorado Medical School, Denver, CO; N.J. Fiumara, M.D., State Dept. of Public Health, Boston, MA; A.R. Hinman, M.D., State Dept. of Public Health, Nashville, TN; R.H. Kampmeier, M.D., Central State Hospital, Nashville, TN; L. Klein, M.D., Grady Memorial Hospital, Atlanta, GA; W. Ledger, M.D., University of Southern California Medical Center, Los Angeles, CA; W. McCormack, M.D., Boston City Hospital, Boston, MA; G. McCracken, M.D., University of Texas Medical Center, Dallas, TX; N.B. Nichols, M.D., University of Oklahoma Health Sciences Center, Oklahoma City, OK; P. Perine, M.D., Virginia Mason Clinic, Seattle, WA; M.F. Rein, M.D., University of Virginia, Charlottesville, VA; J.P. Sanford, M.D., Uniformed Services University of the Health Sciences, Bethesda, MD.; A.L. Schroeter, M.D., Mayo Clinic, Rochester, MN; P.F. Sparling, M.D., University of North Carolina, Chapel Hill, NC; L. Taber, M.D., Baylor College of Medicine, Houston, TX; E.C. Tramont, M.D., LTC, M.C., Walter Reed Army Medical Center, Washington, D.C.

† Italics indicate commentary.

††Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

to hospitalize patients with neurosyphilis, particularly if the patient is symptomatic or has not responded to initial therapy. In these instances, they treat patients with 12-24 million units of aqueous crystalline G given intravenously each day (2-4 million units every 4 hours) for 10 days.

Patients who are allergic to penicillin:

(1) Tetracycline hydrochloride —500 mg 4 times a day by mouth for 30 days. **OR**

(2) Erythromycin (stearate, ethylsuccinate or base)—500 mg 4 times a day by mouth for 30 days.

There are NO published clinical data which adequately document the efficacy of drugs other than penicillin for syphilis of more than 1 year's duration. Cerebrospinal fluid examinations are highly recommended before therapy with these regimens.

SYPHILIS IN PREGNANCY

Evaluation of Pregnant Women

All pregnant women should have a nontreponemal serologic test for syphilis, such as the VDRL or RPR test, at the time of the first prenatal visit. The treponemal tests such as the FTA-ABS test should not be used for routine screening. In women suspected of being at high risk for syphilis, a second nontreponemal test should be performed during the third trimester. Seroreactive patients should be expeditiously evaluated. This evaluation should include a history and physical examination as well as a quantitative nontreponemal test and a confirmatory treponemal test.

If the FTA-ABS test is nonreactive and there is no clinical evidence of syphilis, treatment may be withheld. Both the quantitative nontreponemal test and the confirmatory test should be repeated within 4 weeks. If there is clinical or serologic evidence of syphilis or if the diagnosis of syphilis cannot be excluded with reasonable certainty, the patient should be treated as outlined below.

Patients for whom there is documentation of adequate treatment for syphilis in the past need not be retreated unless there is clinical or serologic evidence of reinfection such as darkfield-positive lesions or a 4-fold titer rise of a quantitative nontreponemal test.

A. For patients at all stages of pregnancy who are not allergic to penicillin: Penicillin in dosage schedules appropriate for the stage of syphilis as recommended for the treatment of nonpregnant patients.

B. For patients of all stages of pregnancy who are allergic to penicillin: Erythromycin (stearate, ethylsuccinate or base) in dosage schedules appropriate for the stage of syphilis, as recommended for the treatment of nonpregnant patients. Although these erythromycin schedules appear safe for mother and fetus, their efficacy is not well established. Therefore, the documentation of penicillin allergy is particulary important before treating a pregnant woman with erythromycin. *Erythromycin estolate and tetracycline are not recommended for syphilitic infections in pregnant women because of potential adverse effects on mother and fetus.*

Follow-up

Pregnant women who have been treated for syphilis should have monthly quantitative nontreponemal serologic tests for the remainder of the current pregnancy. Women who show a 4-fold rise in titer should be retreated. After delivery, follow-up is as outlined for nonpregnant patients.

CONGENITAL SYPHILIS

Congenital syphilis may occur if the mother has syphilis during pregnancy. If the mother has received adequate penicillin treatment during pregnancy, the risk to the infant is minimal. However, all infants should be examined carefully at birth and at frequent intervals thereafter until nontreponemal serologic tests are negative.

Infected infants are frequently asymptomatic at birth and may be seronegative if the maternal infection occurred late in gestation. Infants should be treated at birth if maternal treatment was inadequate, unknown, with drugs other than penicillin, or if adequate follow-up of the infant cannot be ensured.

Infants with congenital syphilis should have a CSF examination before treatment.

Infants with abnormal CSF:

(1) Aqueous crystalline penicillin G, 50,000 units/kg intramuscularly or intravenously daily in 2 divided doses for a minimum of 10 days. **OR**

(2) Aqueous procaine penicillin G, 50,000 units/kg intramuscularly daily for a minimum of 10 days.

Infants with normal CSF:

Benzathine penicillin G, 50,000 units/kg intramuscularly in a single dose. *Although benzathine penicillin has been previously recommended and widely used, published clinical data on its efficacy in congenital neurosyphilis are lacking. If neurosyphilis cannot be excluded, the procaine or aqueous penicillin regimens are recommended. Since cerebrospinal fluid concentrations of penicillin achieved after benzathine penicillin are minimal to nonexistent, these revised recommendations seem more conservative and appropriate until clinical data on the efficacy of benzathine penicillin can be accumulated. Other antibiotics are not recommended for neonatal congenital syphilis.*

Penicillin therapy for congenital syphilis after the neonatal period should be with the same dosages used for neonatal congenital syphilis. For larger children the total dose of penicillin need not exceed the dosage used in adult syphilis of more than 1 year's duration. After the neonatal period, the dosage of erythromycin and tetracycline for congenital syphilitics who are allergic to penicillin should be individualized but need not exceed dosages used in adult syphilis of more than 1 year's duration. Tetracycline should not be given to children less than 8 years of age.

FOLLOW-UP AND RETREATMENT

All patients with early syphilis and congenital syphilis should be encouraged to return for repeat quantitative nontreponemal tests 3, 6, and 12 months after treatment. Patients with syphilis of more than 1 year's duration should also have a repeat serologic test 24 months after treatment. Careful follow-up serologic testing is particularly important in patients treated with antibiotics other than penicillin. Examination of CSF should be planned as part of the last follow-up visit after treatment with alternative antibiotics.

All patients with neurosyphilis must be carefully followed with serologic testing for at least 3 years. In addition, follow-up of these patients should include clinical reevaluation at 6-month intervals and repeat CSF examinations, particularly in patients treated with alternative antibiotics.

The possibility of reinfection should always be considered when retreating patients with early syphilis. A CSF examination should be performed before retreatment unless reinfection and a diagnosis of early syphilis can be established.

Retreatment should be considered when:

(1) Clinical signs or symptoms of syphilis persist or recur;
(2) There is a sustained 4-fold increase in the titer of a nontreponemal test;
(3) An initially high-titer nontreponemal test fails to show a 4-fold decrease within a year.

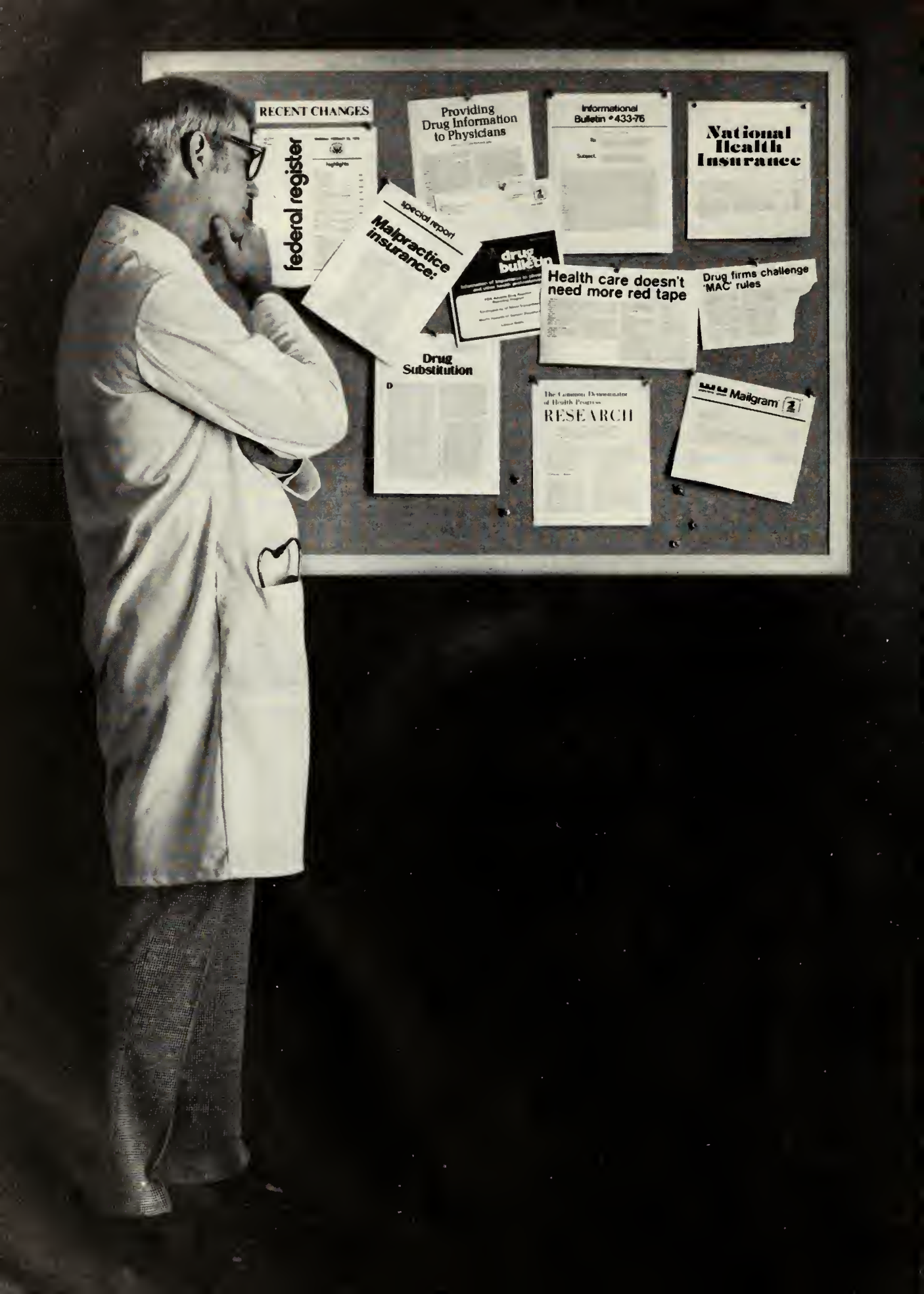
Patients should be retreated with the schedules recommended for syphilis of more than 1 year's duration. In general, only 1 retreatment course is indicated because patients may maintain stable, low titers of nontreponemal tests or have irreversible anatomical damage.

EPIDEMIOLOGIC TREATMENT

Patients who have been exposed to infectious syphilis within the preceding 3 months and other patients who on epidemiologic grounds are at high risk for syphilis should be treated as for early syphilis. Every effort should be made to establish a diagnosis in these cases.—**Reported by Venereal Disease Control Div., Bur. of State Services, Center for Disease Control, Atlanta, Ga.,** in *Morbidity and Mortality Weekly Report,* April 6, 1976.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

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Screening for Genetic Disorders

IRA K. BRANDT, M.D.
Indianapolis

THE relatively recent, impressive developments in the basic medical sciences, such as biochemistry and cytogenetics, have produced significant advances in our understanding and ability to manage a great number of genetic disorders.

While some of these disorders are relatively common, and some may be diagnosed clinically early enough to offer the patient some help, many are rare and not very specific as to symptomatology, and may not be diagnosed until irrevocable damage is done; indeed, some may remain completely asymptomatic until it is too late to apply effective prophylactic therapy.

It is for the latter reason that the state of Indiana, along with most of its sister states, requires that all newborn infants be tested for phenylketonuria (PKU). State legislatures were particularly interested in enacting such laws in the middle sixties when it was demonstrated that the public cost of caring for the usually severely retarded victims of the disorder appreciably exceeded the cost of screening all newborn infants, weeding out the false positives, and treating the truly positive cases so as to prevent mental retardation.

While some state legislatures, particularly those which have central, state-supported laboratories carrying out the PKU testing, recently have amended their laws to include testing for other disorders, such as galactosemia, maple-syrup urine disease, homocystinuria, and others, most states (including Indiana) have allowed their original laws to remain intact, since these have usually contained the modifier "and other similar disorders." The latter would be adequate to permit health departments to accomplish the same end by amending their regulations. Little has been done in the latter group of states to expand their screening programs to include other disorders, however, since the rarity of each, particularly when screened individually in many different small laboratories, is such that cost-benefit analysis is decidedly unfavorable.

The rareness of some is in contrast to their aggregate number (e.g., McKusick[1] lists 141 enzyme defects), however, so that clinical and laboratory tests for their presence may be practicable only if they are broad in their specificity and convenient and efficient enough to be readily available and to enable finite resources of personnel and material to function effectively. Such screening tests serve primarily to alert the physician to the possibility of a disorder or, more usually, of a particular group of disorders. It is axiomatic, therefore, that any positive screening test must be followed by more definitive studies, and that appropriate management facilities be available.

In the remainder of this brief review we will consider genetic screening in the larger sense: any procedures carried out in addition to routine ones to detect genetic disorders in persons who either appear to be normal or who have been ascertained as having an increased potential for having a genetic disorder. We will discuss procedures suggested for the neonatorium, infancy and illnesses; lack of space prevents inclusion of marriage, pregnancy and delivery. While not all can be done at the appointed time because of limitation in resources, we should be aware of their powerful potential, particularly when we plan future programs. Needless to say, the lists cannot be accepted uncritically since mass screening technics for some disorders have not been proven to be effective, and since opinion does vary as to the desired degree of comprehensiveness.

Immediate Neonatorium

This is probably the most significant time for screening. Anoma-

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lies should be sought. Symptoms such as vomiting, lethargy, tachypnea, stupor and hypotonia may foretell serious metabolic disease, as may the perception of an unusual odor. Some persons would feel that a buccal smear is indicated to determine whether there are an unusual number of X chromosomes; for example, the incidence of Klinefelter syndrome (chromosome pattern 47,XXY) is about one per 800 male babies, and the incidence of multiple-X about one per 600 girls. XO girls (Turner syndrome) are rarer, one per 2,500. The blood may be studied for phenylalanine (as required by Indiana state law) as well as other substances such as galactose, sickle-cell and other abnormal hemoglobins, glucose-6-phosphate dehydrogenase deficiency, maple syrup urine disease, etc. The urine may be studied by a simple screening test (such as the Multistix and Clinitest) which would detect a number of abnormal metabolites. The stools may be studied for the presence of albumin as an indicator of cystic fibrosis and for the presence of reducing substances by means of Clinitest. It is of some importance that girls with phenylketonuria in rare instances may not be detected by the usual screening simply because not all have an elevated phenylalanine until the age of about five days; it may be well to postpone the determination until that time. The present recommendation of the Indiana State Board of Health (issued Feb. 4, 1966) is that "the [PKU] test shall be done prior to an infant's discharge from the hospital" and that "all infants be retested for PKU at 4-6 weeks" and that "procedures using blood are the only methods now known to be satisfactory for detecting PKU in the first few days of life."

Two to Four Weeks of Age

As for the early neonatorium, with addition of a metabolic screening of the urine (include amino acids and organic acids).

Infancy

During this period one should continue to look for physical abnormalities. Additional findings which should be sought include unusual hair color (partial albinism, cystinosis, Chediak-Higashi syndrome, etc.) or appearance (Menkes kinky-hair syndrome, argininosuccinic aciduria, Netherton syndrome, etc.) and the stability of the iris in the eyes (iridodonesis would suggest Marfan syndrome and homocystinuria, but may be part of other disorders and may exist as a single autosomal dominantly transmitted trait). During this period the ceruloplasmin concentration, quite low in the neonate, usually rises to near-adult values and one may thus screen for Wilson disease. Pilot studies are under way to test the validity of screening for hyperlipoproteinemias and prophylactic therapy thereof.

Overt Disorders

At any time of life when abnormal states occur, special attention must be paid to the possibility of a genetic disorder. Mental retardation, failure to thrive, neurological deficits or an acute metabolic disorder should lead to an appropriate physical and laboratory evaluation.

Attention is directed to the acute metabolic disorders, since genetic etiological factors are frequently overlooked in the necessarily greater concern for the immediate survival of the patient. An infant or young child who presents with vomiting, tachypnea, lethargy, stupor, hypotonia and dehydration, with or without ketoacidosis, must be suspected of having a metabolic disorder which may lead to mental and physical disabilities, if not death, unless appropriate diagnostic and therapeutic measures are undertaken without delay. Feeding of milk and all other foods, particularly those which contain protein, should be discontinued in favor of the administration of a balanced electrolyte-glucose solution, intravenously if necessary. The urine should be tested immediately for odor, reducing substances, ketones, specific gravity, pH and ferric chloride chromagens, and the rest sent to the laboratory to be processed for studies of amino acids and other organic acids; if these tests cannot be done immediately, the specimen should be fresh-frozen. Blood should be obtained for electrolytes (anion gap), glucose, lactate, ammonia, amino acids and organic acids. These procedures will screen for a large number of disorders (propionic acidemia, isovaleric acidemia or the "sweaty-sock syndrome," and maple-syrup urine disease are some examples) and should bring about amelioration of many of them.

Conclusion

The concept of genetic screening, and of screening in general, has come under intense scrutiny only recently, and has not yet been sufficiently developed to enable realization of its technical potential. Limitations of personnel, facilities and funding are obvious. Less obvious are the very real problems involved in carrying out such procedures on large populations of persons who cannot be expected to have enough understanding of the implications of positive results to preclude misunderstanding and the resultant social, emotional and economic difficulties which may result; the first step in a screening program must be community education. Two publications[2,3] survey these problems rather well and refer to more comprehensive reviews.

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Child Abuse and Neglect

A Child Abuse and Neglect Committee was recently established by the Indiana Chapter of the American Academy of Pediatrics. Why was the creation of this committee necessary? The neglect and abuse of children is receiving attention due to heightened awareness by professionals and by the general public. There appears to be an increasing rate of maltreatment of children and, although some of the increase is due to better identification and reporting procedures, there is probably also an absolute increase in the number of children who are maltreated. Conservative estimates place the number of abuse cases in the United States at 250,000 children annually.

Often Self-perpetuating

We are also interested in doing something about child abuse and neglect because of its impact on society. A sizeable proportion of children in school who are diagnosed as having minimal brain damage, cerebral palsy, perceptual and learning problems and retardation, have been abused earlier in life. Later, many abused children become juvenile delinquents and may eventually end up incarcerated. In many cases, when abused children become parents, they become the next generation of abusive, neglecting parents. Child abuse is self-perpetuating, and something must be done to stop the cycle.

There is a wide range of physical and radiological findings in abused or neglected children. There may be evidence of malnutrition (failure to thrive) or poor skin care. Old and new bruises, burns, abrasions and scars may be present. Ten percent of childhood trauma cases seen in emergency rooms are suspected of being from child abuse. Most abused or neglected children are withdrawn and extremely irritable when examined. Radiologically, there may be evidence of old or new fractures. If physical abuse is suspected, x-rays of the ribs, long bones and skull are a necessity.

The physician is in a key position to suspect individual cases of child abuse. In Indiana, physicians are mandated by law to report to the county welfare department or law enforcement agency any *suspected* case of child abuse. Doctors are protected from civil or criminal liability if the report is made in good faith. However, many physicians are reluctant to report suspected cases of abuse or neglect. They may feel that the evidence won't stand up in court, or perhaps they are unwilling to become involved in potential legal action. In truth, most cases do not end up in court. In cases which do go to court, few difficulties arise if the report was made in good faith, and if the findings are well documented.

Other physicians distrust protective services to make rehabilitative changes. Unfortunately, it is the child who suffers in these cases. If a child who is abused is returned to home without intervention, 5% are killed and 35% are reinjured. Moreover, the untreated families tend to produce children who grow up to be juvenile delinquents and criminals, as well as the child batterers of the next generation. In many instances, the abusive incident represents the parents' cry for help and the family is actually relieved when a physician reports the case. If the physician is willing to get involved, he may be able to add his talents to those of the protective services and improve the rehabilitative potential of these departments. An expected success rate of up to 90% may be anticipated with appropriate treatment.

The current area of concern of our committee is the proposed Child Abuse Law. The proposed bill died in the last legislative session, but it is expected that another attempt at passage will be made this fall. The proposed bill attempted to restructure the previous Indiana Child Abuse Law in the following ways:

1) provide a definition of child abuse and neglect

2) form a child protective unit for investigation, intervention and rehabilitation of possible abusive families

3) appoint an attorney to represent the best interest of the child in legal proceedings

4) with community input, develop a local plan for child protective services

5) provide a multidisciplinary review team to aid the child protective unit, and

6) include neglect in reporting procedure.

New Law Needed

With rejection of this proposed bill, the following becomes apparent: 1) the county child welfare staff will continue to be inadequate in size to appropriately serve in abuse cases, 2) it will continue to be easier to place a child in foster care than to attempt to work with the family in the home, 3) we will continue to see an "all or none" phenomenon in many welfare departments, whereby an abuse or neglect case is either severe enough to require the child's removal from the home, or else the case is not severe enough to require removal, and nothing is done.

It is our committee's hope that with physicians' and legislators'

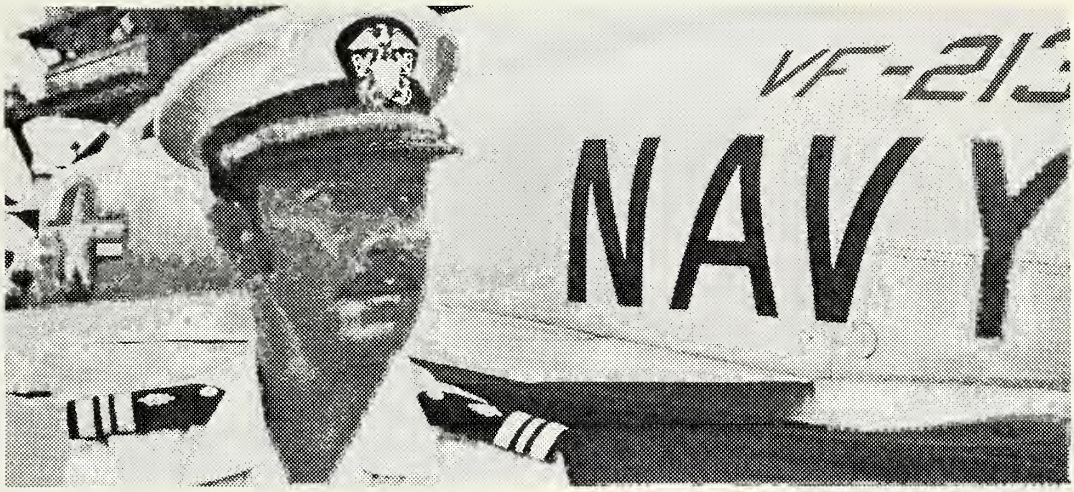
This paper has been approved by the Executive Committee of the Indiana Academy of Pediatrics.

help, a new and better law can be passed in the next legislative session. We welcome any enthusiasm physicians in Indiana can generate in their local communities to ensure the passage of a more adequate law to protect children. It is not our intent, nor the intent of the law's other proponents, to tell parents how to rear or punish their children, but only to be able to intervene when such practices are done to the child's real detriment.

Our committee welcomes any comments or support that Indiana physicians may wish to offer. Please address your response to: Gabriel Rosenberg M.D., Methodist Hospital, 1604 N. Capitol Ave., Indianapolis, 46202.

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Health Care Services in Local Detention Facilities (Jails)

EDWARD M. BRECHER
RICHARD D. DELLA PENNA, M.D.

THE term "jail" covers a very broad spectrum of local and county institutions. Some are empty during much of the year and rarely hold more than a few inmates at any one time. Others are among the largest of all institutions, holding thousands of jailed persons on any given day—and admitting tens of thousands during the year. Some are located next door to hospitals offering a full range of health services, which may (or may not) be available to the jail inmates. Others are in remote communities, lacking adequate health care facilities even for the outside population.

Jailed persons, moreover, are an astonishingly variegated group. Most have been convicted of no crime but are being held, awaiting trial. A few are not even accused of a crime but are being held as material witnesses. Some may stay only a few hours or days until bail is posted, or they are released on their own recognizance. Others, however, stay a year or longer—either awaiting trials which are delayed, or awaiting the outcome of a prolonged series of appeals, or because they are serving consecutive one-year sentences for misdemeanors. For some, the jail is almost a permanent residence; their repeated periods of incarceration are punctuated by only brief "vacations" on the street between offenses. In many communities the jail also serves as the dumping ground for drunks and persons under the influence of drugs; these alcohol, barbiturate, and heroin admissions often constitute a large proportion of total jail admissions. A significant proportion of those admitted are mentally disordered—and mental disorder rather than criminal behavior may be the reason for the incarceration.

To expect the county sheriff or the jail warden personally to establish and maintain adequate health care services in these institutions, in addition to carrying out his countless other responsibilities, is in most cases wholly unrealistic. The warden or sheriff is not selected for his competence in the field of health care administration. In this chapter, accordingly, we shall first be concerned with ways of securing competent health care administration and services for the thousands of jails in the country, and then with the major problem which distinguishes local detention facilities from long-term institutions—the flooding of the jail health care system by vast numbers of very-short-stay admissions. We shall also call attention to potential usefulness of the jail as a crucial element in the overall case-finding activities of community health care services—and the resulting benefits to the health of the entire community.

5.1. Administrative Considerations

Wherever feasible, health care services in local and county correctional institutions should be made the responsibility of a competent civilian health care delivery organization rather than of the law-enforcement or correctional agency.

In some situations, the city or county health department, or a city or county hospital, may be the appropriate agency to administer health care services in the jail. Elsewhere, health care services may be "contracted out" to a community hospital or clinic, a prepaid group health plan, or a health maintenance organization (HMO); or a medical partnership may be employed to provide and administer services (much as some hospitals "contract

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Model jail health programs are currently being developed under a grant to the American Medical Association by the Law Enforcement Assistance Administration. (Indiana is one of six states conducting the study for the AMA.)

out" their emergency room services to a medical partnership). Santa Clara County, California, is an excellent example of jail health care delivery provided by a county-operated community hospital. San Francisco is an example of health care delivery in the city-county jail, recently transferred under court order to the city-county health department.

There are, no doubt, a few warranted exceptions to this principle of "contracting out" jail health care services. In a few large cities and counties where the warden or sheriff has already established an adequate health care system, no purpose may be served by transferring health care to an outside agency. The same may be true in cities or counties where no civilian organization exists which is capable of delivering adequate care. With these and perhaps a few other exceptions, however, health care in jails should be organized, administered, and delivered by an agency or organization whose primary mission is health.

5.2. Statewide Standards

Health care standards for jails in a state should be set by state law or regulation. California, Kentucky and other states have taken or are currently taking steps in this direction.

Technical assistance in meeting these standards should be sought from local and county medical societies and other local health organizations; and in addition state departments of corrections should be given the responsibility, by law or regulation, of providing technical assistance in upgrading the health care services of local and county jails.

After a reasonable period for achieving compliance, the state departments of corrections and state health departments should monitor compliance with the health care standards, and jails unable to meet those standards should be superseded by regional jails with adequate health care facilities.

At least two states, Connecticut and Alaska, have gone much further and operate all of the jails in the state as part of the statewide correctional system.

5.3. Cooperative Health Care Plans

The independent local and county jail has deep roots in American constitutional law, history, and tradition. This does not mean, however, that the health care services in each jail must be operated as an isolated and independent enclave. Cooperation in health care delivery among jails, and between jails and state correctional institutions, is today the exception rather than the rule. Yet cooperation might do much to provide quality health care at moderate cost in both jails and state institutions.

One example is California, where state law mandates the treatment of jail inmates in the state correctional hospital under certain circumstances. Another example is Minnesota, where a recently opened secure unit in the St. Paul Ramsey County Hospital serves patients in need of hospitalization from the Ramsey County Jail as well as from state correctional institutions. In some states it may prove feasible to establish a statewide correctional health care system in which all of the state's inmates from the jails as well as the state institutions, are served by a limited number of geographically well distributed state correctional hospitals and secure units in civilian hospitals.

Traditionally, resistance to jail regionalization has come from county sheriffs who are made responsible by the state constitution for the administration of the county jails. This resistance is certainly understandable. In at least some states, however, as a result of litigation and other pressures, county sheriffs may already see health care delivery in their jails as a problem they would be delighted to delegate to a competent outside agency. As health care becomes even more complex, as the gap between health care in jails and health care outside continues to widen, and as pressures to close the gap continue to build up, more and more county sheriffs and local jail wardens are likely to see the "contracting out" of jail health care services as an opportunity rather than as a threat to their autonomy.

5.4. The Large Jail and Its Revolving-Door Problem

Even a jail which houses only a dozen inmates on any given day may admit and discharge hundreds during the course of a year. A jail with an average daily population of a thousand may admit and discharge fifty thousand per year. So long as this revolving-door policy continues, it will remain difficult to provide for all jailed persons the basic health services described throughout this manual. The shortest route to a significant upgrading of jail health services is to reduce the flow of unnecessarily incarcerated persons through the jails.

It is not just the "criminal element" whose health is threatened by current revolving-door policies; the jail without adequate health care constitutes a menace to the entire community—a health menace likely to remain so long as our jails continue to admit vast numbers of persons unnecessarily.

The principal approaches to reducing unnecessary jail admissions are (a) bail reform and (b) the diversion of alcoholics and drug users from the jail to treatment centers.

Bail reform. In New York City, the average cost per jail admission is $246; many persons are jailed at this cost for lack of $50 or $100 in bail. A nationwide jail study indicates that 40% of all jail admissions are persons eligible for bail but unable to raise it.

Alcohol and drug diversion. Public drunkenness is the cause of another very large proportion of all jail admissions. This continues to be the case in some jurisdictions despite repeated court holdings that drunkenness constitutes a medical rather than a criminal justice problem.

Using the jail as a dumping ground for drunks is also a *dangerous* policy; for *delirium tremens* (a common complication of "cold turkey" alcohol withdrawal) is a life-threatening condition. Continuous nursing surveillance under medical supervision and well-controlled medication during withdrawal are necessities. The jail is inherently unsuitable as the scene for alcohol detoxification.

Barbiturate detoxification is closely parallel to alcohol detoxification, and the same considerations apply.

Heroin detoxification is rarely as dangerous as alcohol and barbiturate detoxification, but it is also better and more economically managed in a treatment center rather than a jail.

Changes in policy affecting bail, drunks, and drug cases can readily cut jail admissions in half in almost any jurisdiction. Excessive jailing is damaging to those unnecessarily incarcerated, socially counter-productive, and grossly wasteful of community resources and tax funds—in addition to inundating the jail's health care service with burdens far beyond its capacity.

The sheriff or jail warden, of course, is not responsible for these self-defeating intake policies. Under the law, he must take custody of all persons brought in by duly constituted authorities. Yet jail crowding and substandard jail conditions are inevitably blamed on his department. In self-protection as well as in the interest of improved jail conditions, he should take the lead in urging that unnecessary jail admissions be reduced to minimum.

5.5 Admission Procedures in Jails

The admission procedures recommended in Chapter 1—immediate screening by qualified health care personnel for trauma, infectious diseases, other mental and physical illnesses, and for alcohol or drug intoxication, plus the subsequent taking of a complete medical history, a physical examination including indicated laboratory tests, and a health evaluation—is even more important in a jail than in a long-term correctional institution; for those admitted to jails come straight in off the streets and are far more likely than those admitted to long-term institutions to suffer health or mental health problems requiring immediate identification and care. Providing these costly intake services to the vast numbers of persons admitted has benefits which extend far beyond the boundaries of the jail. A basic change in the *philosophy* governing the provision of these admission services is therefore recommended.

Each city, county, and state has a responsibility to foster the physical and mental health of its residents. This responsibility goes beyond assuring that medical care is available for those who seek it. *Case-finding programs* to identify and bring into treatment persons in need of care has for decades been a basic function of city, county, and state health services. These case-finding programs include the tracking down of contacts of persons with infectious diseases, the screening of large numbers of apparently healthy people for non-infectious diseases (hypertension, heart disease, cancer, etc.), a wide range of mental health outreach programs, and other examples. Voluntary health organizations—the heart association, the lung association, the cancer society, and so on—also mount large-scale and valuable case-finding programs in many communities. The purpose is to protect the community as well as to serve the individuals screened. Experience has shown that a dollar spent in case-finding may save hundreds of dollars in subsequent community costs for the long-term care of chronic disease and disability.

The ideal focus for almost all such public health and voluntary case-finding programs is the population which circulates through the local jails. The incidence of unmet health needs is much higher in this population than in any other. No other high-risk population is as readily accessible in a single place at convenient times. The cost of case finding per case found will almost certainly prove to be much lower in jails than elsewhere as a result of these two combined factors.

Yet, curiously enough, instead of being recognized as the population warranting the highest priority, the jail population is often overlooked in these public and voluntary case-finding programs.

One example among many is the public health VD program. Numerous studies have shown that the asymptomatic female with gonorrhea is one of the major factors in the current nationwide gonorrhea epidemic. Accordingly, a nationwide program for screening asymptomatic females for gonorrhea is fostered by the U.S. Center for Disease Control. The program is funded jointly by Federal, state, and local public health agencies. More than five million women without symptoms were screened last year. Among the groups screened in this program have been suburban housewives attending family planning clinics, college undergraduates and the patients of private physicians. The cost of the screening program per case found in such groups is very high, since the ratio of positive to negative findings is quite low. The screening of women admitted to city and county jails would be far less costly per case found; and since many prostitutes and other women with multiple sex partners pass through the jails, the number of subsequent infections prevented per case found would no doubt be very high. Yet in very few jails is screening for asymptomatic gonorrhea made available to all females entering the jail system.

Closely related to screening for asymptomatic gonorrhea is pap test screening for cancer of the cervix. The number of cases of this form of cancer and the age at which it occurs are related to intercourse at an early age, to experience with multiple sexual partners, and to other factors frequently found in jail populations. Women entering jails are a high-risk group for cancer of the cervix as well as for VD.

Specimens for the pap test can be secured at the same time as the gonorrhea culture specimen, with a trivial increase in the amount of time required. Yet only in a few jails, are routine pap tests for cancer of the cervix made available to all women admitted to the jail system.

Tuberculosis case-finding constitutes an equally dramatic example of the importance of case-finding in the jail setting. When a single case is found, many subsequent tuberculosis infections in the outside community can be readily aborted or prevented. This is done in part by rendering the patient himself or herself non-infectious as early as possible, in part by educating him or her in sanitary measures for preventing further spread, and in part by providing prophylactic medication for close associates already exposed. At few other sites in the community can fresh TB infections be diagnosed at so low a cost per case found as in the jail.

5.6. Summary

Jail health services should (with some exceptions) be delivered and administered by a community organization whose primary mission is health care. Minimizing jail admissions through bail reform and through diversion of alcohol and drug cases is an essential preliminary step toward adequate jail health care and community health protection. The jail should be viewed as a central resource in case-finding activities. In other respects, jail health care should closely parallel the patterns of health care delivery described in other portions of this study. ◄

Informative Program on Medical Office Management Planned for Convention

One of the interesting and informative programs which will be offered this year at the Annual Convention of the Indiana State Medical Association is a Practice Management Seminar.

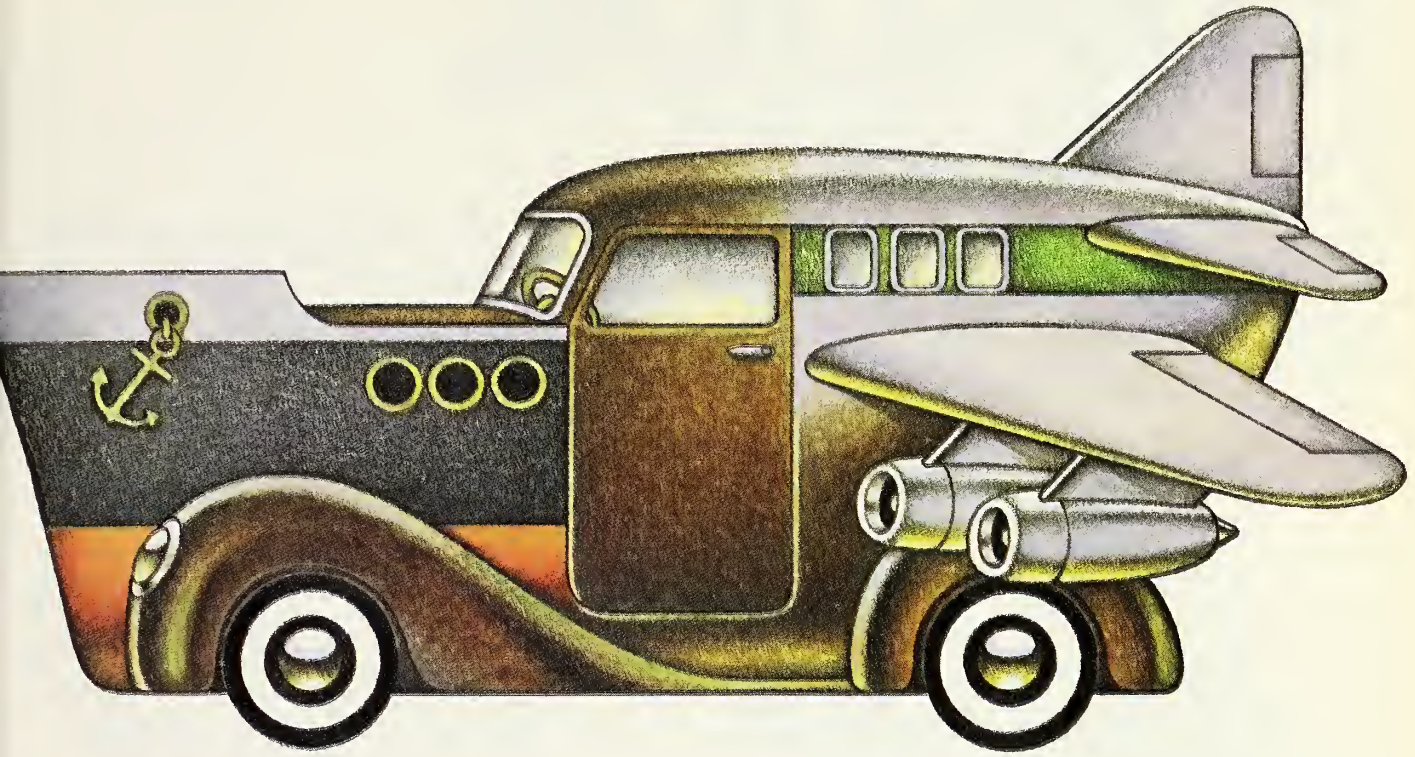
The program will be held on Sunday, Oct. 10, in the Columbia Club from 9 a.m. to 4 p.m. Cost for each participant will be $40, which will cover the price of the workbooks and luncheon. The program will be limited to 50 physicians.

The program is being offered to update physicians, and especially new physicians on technics in managing the many business aspects of medical practice.

Although the course curriculum is not yet set, that information will be sent to ISMA members within the next few weeks in a special promotional brochure.

Clayton L. Scroggins Associates of Cincinnati will conduct the program on such subjects as business records, personnel needs, office methods and procedures, collections, financial planning and others.

Make your plans today to attend the entire ISMA Convention from Oct. 10 through 12. Although the Practice Management Program will be held at the Columbia Club, all other events for the Convention will take place at the Indianapolis Hilton.



On land, sea, and in the air...

Up to 24 hours of effective control with a single dose...in nausea, vomiting and dizziness associated with motion sickness.

Dosage: 25 to 50 mg. 1 hour before travel.

Available on prescription only.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

CONTRAINDICATIONS. Administration of Antivert during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

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(meclizine HCl) 25 mg.
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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F literature or *PDR*. The following is a brief summary.

* **Warning**
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

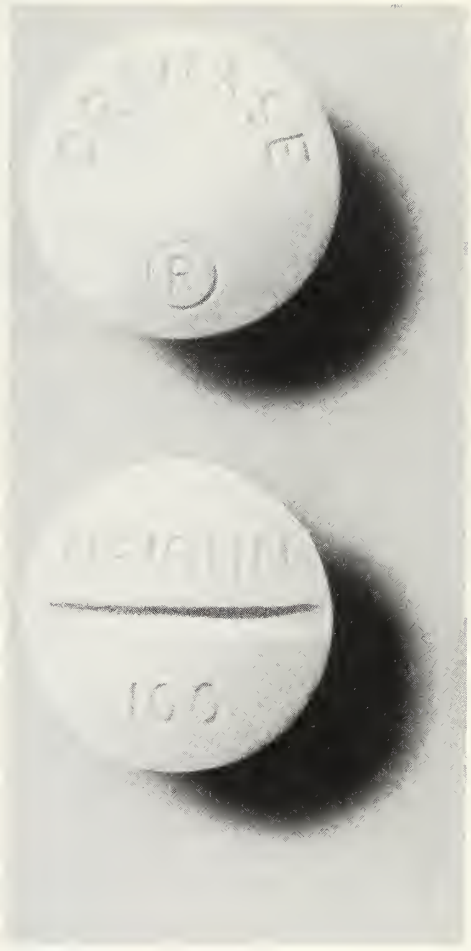
Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

Supplied: Bottles of 100 capsules; in Single Unit Packages of 100 (intended for institutional use only).

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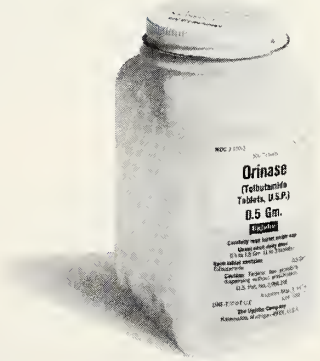
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WHEN ANXIETY INTERFERES.

The cardiac patient and anxiety.



"The [cardiac] patient is anxious about minor symptoms, about the implications of his diagnosis, and about real or imagined limitations of function."*

The worst is over. The cardiac patient is out of the acute stage, out of the hospital, and well on his way to recovery. How quickly he comes back to near normal functioning may depend on his psychological as well as his physical rehabilitation.

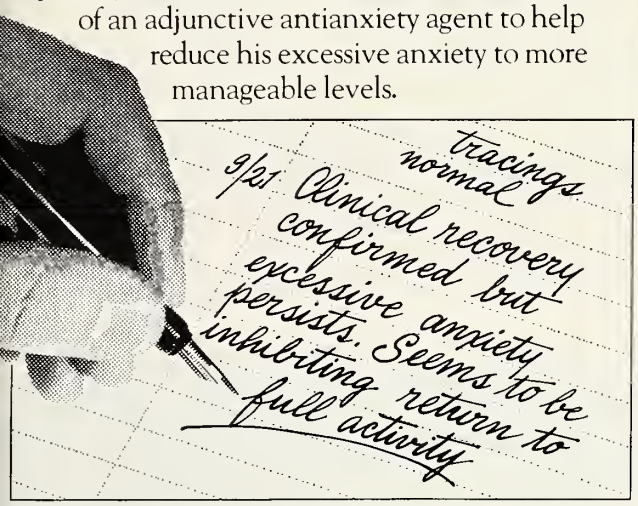
Clinical anxiety, for example, may be one reason for prolonged recuperation following cardiac healing. Yet anxiety can sometimes be beneficial in facilitating patient compliance.

The patient who is realistically concerned about resuming his precoronary functioning may be highly motivated to adhere to his rehabilitation regimen. However, the cardiac patient with *excessive* or unresolved anxiety may be so fearful of future heart failure that he refrains from your prescribed regimen. These excessively anxious cardiac patients eventually present the same clinical characteristics as patients deconditioned by bed rest.

Excessive anxiety can interfere with patient management

When excessive anxiety diminishes your

patient's ability to participate fully in his rehabilitation program, your counseling and reassurance are often sufficient. But when his anxiety is so great that it actually interferes with his ability to listen and respond, you may want to consider the addition of an adjunctive antianxiety agent to help reduce his excessive anxiety to more manageable levels.



Librium® (chlordiazepoxide HCl) an effective adjunct to your reassurance and counseling

Safety: Librium has a highly favorable benefits-to-risk ratio and a wide margin of safety. Because of its low incidence of side effects, it is regarded as one of the safest antianxiety agents available. And Librium does not adversely affect the cardiovascular system. See complete product information for warnings, precautions and adverse reactions.

Performance: Hundreds of clinical trials, thousands of published papers, and millions of patients comprise the record of performance for Librium.

Concomitant use: Of special significance in treating the cardiac patient already taking multiple agents is the fact that Librium is used concomitantly with most primary medications, such as cardiac glycosides, diuretics and antihypertensives.

*Zohman BL: *Geriatrics* 28:110-119, Feb 1973

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of childbearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (*e.g.*, excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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THE ANXIETY-SPECIFIC

VISUAL FOCUS ON ACUTE GOUTY ARTHRITIS



Foot of patient with acute gouty arthritis as seen by conventional x-ray.



Scintiphotogram of same foot reflects inflammatory process.

The scintiphotograph on the right shows increased uptake of radiotechnetium polyphosphate in the metatarsophalangeal joint and the proximal interphalangeal joint of the great toe of a patient with acute gouty arthritis. This increased uptake probably results from increased vascularity in the affected areas.

For a more detailed description of scintiphotography, see "addendum" at right.

THERAPEUTIC FOCUS ON

CAPSULES, 25 mg and 50 mg

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[INDOMETHACIN | MSD]

helps relieve pain and other symptoms of inflammation in acute gouty arthritis in selected patients

INDOCIN is a potent drug with anti-inflammatory, antipyretic, and analgesic properties. It should not be used in conditions other than those recommended. Although INDOCIN does not alter the progressive course of the underlying disease, in selected patients with acute gouty arthritis it has been found highly effective in relieving pain and in reducing fever, swelling, and tenderness.

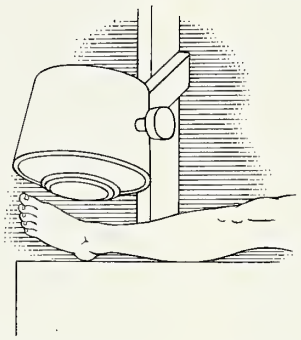
MSD
MERCK SHARP & DOHME

For a brief summary of prescribing information, please see following page.

addendum

MSD
MERCK SHARP & DOHME

Facts about Scintiphotography



In recent years a variety of radiopharmaceuticals have been employed to aid in the diagnosis of bone and joint disorders. The joint-imaging technique consists of injecting technetium polyphosphate intravenously, and imaging is performed with the scintillation camera two hours after the administration of the radionuclide. In general, for joint surveying, the shoulders, elbows, hands, wrists, knees, ankles, feet, and vertebral column are mapped. The entire scanning process takes approximately one hour. The criterion for a positive image is a higher concentration of radioactivity in a joint region than in adjacent nonarticular bone. In effect, each patient serves as his own control.

INDOCIN®
(INDOMETHACIN | MSD)



helps relieve pain
and other symptoms
of inflammation
in acute
gouty arthritis
in selected patients

IMPORTANT NOTE: INDOCIN (Indomethacin, MSD) cannot be considered a simple analgesic and should not be used in conditions other than those recommended. The drug should not be prescribed for children because safe conditions for use have not been established.

Because of the high potency of the drug and the variability of its potential to cause adverse reactions, the following are strongly recommended: 1) the lowest possible effective dose for the individual patient should be prescribed. Increased dosage tends to increase adverse effects, particularly in doses over 150-200 mg per day, without corresponding clinical benefits; 2) careful instructions to, and observations of, the individual patient are essential to the prevention of serious and irreversible, including fatal, adverse reactions, especially in the aging patient.

Contraindications: Children 14 years of age and under; pregnant women and nursing mothers; active gastrointestinal lesions or history of recurrent gastrointestinal lesions; allergy to aspirin or indomethacin.

Warnings: *Gastrointestinal Effects:* Because of the occurrence and, at times, severity of gastrointestinal reactions, be continuously alert for any sign or symptom signaling a possible gastrointestinal reaction. The risks of continuing therapy with INDOCIN in the face of such symptoms must be weighed against the possible benefits to the individual patient. Gastrointestinal effects may be reduced by giving the drug immediately after meals, with food, or with antacids. Use greater care in aging patients.

Ocular Effects: Corneal deposits and retinal disturbances, including those of the macula, have been observed in some patients on prolonged therapy. Discontinue therapy if such changes are observed. Ophthalmologic examination at periodic intervals is desirable in patients on prolonged therapy.

Central Nervous System Effects: INDOCIN may aggravate psychiatric disturbances, epilepsy, and parkinsonism, and should be used with considerable caution in patients with these conditions. If severe CNS adverse reactions develop, discontinue the drug.

Precautions: Blurred vision may be a significant symptom that warrants a thorough ophthalmologic examination. Patients should be cautioned about engaging in activities requiring mental alertness and motor coordination, as driving a car. Headache which persists despite dosage reduction requires complete cessation of the drug. May mask the usual signs and symptoms of infection; therefore, the physician must be continually on the alert for this and should use the drug with extra care in the presence of existing controlled infection. After the acute phase of the disease is under control, an attempt to reduce the daily dose should be made repeatedly until the patient is off entirely.

Drug Interactions: Although INDOCIN has not influenced the hypoprothrombinemia produced by anticoagulants, patients on anticoagulant therapy should be observed closely for alterations in prothrombin time. In patients receiving probenecid, plasma levels of indomethacin are likely to be increased and a lower total daily dose of INDOCIN may produce a therapeutic effect; increases in the dose of INDOCIN should be made cautiously and in small increments.

Adverse Reactions: *Gastrointestinal Reactions:* Single or multiple ulcerations of the esophagus, stomach, duodenum, or small intestine, including perforation and hemorrhage, with fatalities in some instances; rarely, intestinal ulceration has been associated with stenosis and obstruction; gastrointestinal bleeding without obvious ulcer formation; perforation of preexisting sigmoid lesions (diverticulum, carcinoma, etc.); rarely, increased abdominal pain in ulcerative colitis patients or development of ulcerative colitis and regional ileitis; gastritis may persist after the cessation of the drug; nausea, vomiting, anorexia, epigastric distress, abdominal pain, and diarrhea.

Eye Reactions: Corneal deposits and retinal disturbances, including those of the macula, have been observed on prolonged therapy; blurring of vision.

Hepatic Reactions: Rarely, toxic hepatitis and jaundice, including some fatal cases.

Hematologic Reactions: Aplastic anemia, hemolytic anemia, bone marrow depression, agranulocytosis, leukopenia, and thrombocytopenic purpura may occur rarely. Since some patients manifest anemia secondary to obvious or occult gastrointestinal bleeding, appropriate blood determinations are recommended.

Hypersensitivity Reactions: Acute respiratory distress, a rapid fall in blood pressure resembling a shock-like state, angioedema, dyspnea, asthma, angiitis, pruritus, urticaria, skin rashes, purpura.

Ear Reactions: Hearing disturbances—deafness reported rarely; tinnitus.

Central Nervous System Reactions: Psychic disturbances including psychotic episodes, depersonalization, depression, and mental confusion; coma; convulsions; peripheral neuropathy; drowsiness; lightheadedness; dizziness; syncope; headache.

Cardiovascular-Renal Reactions: Edema, elevation of blood pressure, hematuria.

Dermatologic Reactions: Loss of hair, erythema nodosum.

Miscellaneous: Rarely, vaginal bleeding, hyperglycemia, glycosuria, ulcerative stomatitis, and epistaxis.

Supplied: Capsules containing 25 mg indomethacin each, in single-unit packages of 100 and bottles of 100 and 1000; capsules containing 50 mg indomethacin each, in single-unit packages of 100 and bottles of 100.

For more detailed information, consult your MSD representative or see full prescribing information. Merck Sharp & Dohme, Division of Merck & Co., Inc., West Point, Pa. 19486

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THE INDIANA STATE MEDICAL ASSOCIATION

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Devoted to the interests of the medical profession of Indiana

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Guest Editorial

The Health Planning Act—A Gigantic Danger

WE physicians can be so absorbed by our day-to-day problems that we overlook a gigantic danger now building up—a danger that could compound many of our problems and create new ones.

It's the Health Planning Act of 1974. This law is not just another governmental abstraction. It's not just a sauced-up rehash of Comprehensive Health Planning, the Region Medical Program, and so forth.

Quite to the contrary, it's the framework for a bureaucratic totalitarianism that could reshape the health-care system as we know it—including the responsibilities and expandability of hospitals and other facilities and even the rates they charge.

Moves to put doctors' offices and fees within the scope of the act are afoot in the Department of Health, Education, and Welfare, even though the AMA got them excluded from the law.

Certainly there must be planning. And certainly we must avoid costly overbuilding and overstocking of hospitals. Consider some of the ways, however, in which the Health Planning Act would flout the principles of rational planning, be a heavy expense in itself, and imperil the quality of care.

* The Secretary of HEW is to dominate five somewhat overlapping levels of federal, state and local authority. He is also to issue national health planning policy; appoint a national advisory council; approve state and local planning agencies and the funds they receive, and establish the criteria and procedures they use.
* Certificate-of-need legislation must be adopted in all states, as prescribed by the HEW Secretary. The need for all new institutional facilities and services must be certified; the need for all existent institutional services must be reviewed every five years. Practice-profile data from PSROs, plus the minority status of direct providers of care on local planning boards, could arbitrarily influence the expansion or continuation of services.
* Up to six states are to get federal grants to demonstrate rate regulation for health services. This could become mandatory for all states and encompass physicians, if various planners get their way. The result of regulation is likely to be an obsession with cost at the expense of high-quality care.

The AMA has petitioned a federal court to join the State of North Carolina in a suit aimed at voiding the law. But adjudication can take many months. Meanwhile, physicians in many parts of the country are seeking adequate representation on local planning boards, showing up at public hearings pursuant to the law and otherwise fighting the great potential danger. For the moment there is no other game in town.—**AMA Public Affairs Division.** ◄

ISMA Commission Seeks Changes in Constitution

THE Commission on Constitution and Bylaws of the Indiana State Medical Association will present to the House of Delegates of the Association, in October 1976, the following revised Constitution.

For your additional information, the Commission in its study and revisions has discovered duplication of material in the Constitution and Bylaws. This new approach streamlines the Constitution, eliminates the duplications and incorporates other material currently contained in the Constitution into the Bylaws and simplifies understanding and readability of the document.

Changes in Bylaws will be presented to the House of Delegates at the first meeting of the House in October.

The following is the excerpt from the current Constitution explaining the process of revision:

ARTICLE XIV—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in *The Journal* of this Association.

Constitution

ARTICLE I—TITLE AND DEFINITION

The name of this organization is the Indiana State Medical Association. It is the federacy of Indiana county medical societies.

ARTICLE II—PURPOSES

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the state of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly relations among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care and public health so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies are those county and district medical societies contained within the state of Indiana, and who hold charters from this Association.

ARTICLE IV—MEMBERS

The Indiana State Medical Association is composed of individual members of county medical societies and others as shall be provided in the Bylaws.

ARTICLE V—HOUSE OF DELEGATES

The legislative and policy-making body of the Association is the House of Delegates composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in the Constitution and Bylaws and shall elect the general officers, except trustees, as otherwise provided in the Bylaws.

ARTICLE VI—OFFICERS

The general officers of the Association shall be a president, president-elect, immediate past president, executive director, treasurer, assistant treasurer, speaker, vice speaker, and the trustees. Their qualifications and terms of office shall be provided in the Bylaws.

ARTICLE VII—TRUSTEES

The Board of Trustees is composed of trustees and alternate trustees elected by the component district medical societies, and the president, the president-elect, treasurer, immediate past president, the assistant treasurer, with power to vote only in the absence of the treasurer, and the speaker and vice speaker without power to vote and the executive director without power to vote. The alternate trustees have power to vote only in the absence of the trustee.

ARTICLE VIII—THE CONVENTION

The House of Delegates and the general scientific program shall be convened annually and

at such other times as deemed necessary or as provided in the Bylaws, in cities recommended by the Board of Trustees and approved by the House of Delegates.

ARTICLE IX—FUNDS, DUES AND ASSESSMENTS

Funds may be raised by annual dues or by assessment of the active members on recommendation of the Board of Trustees or any other manner approved by the House of Delegates. Any change in dues or any assessment must be approved by the House of Delegates.

ARTICLE X—AMENDMENTS

The House of Delegates may amend this Constitution at any convention provided the proposed amendment shall have been introduced at the preceding annual convention and provided two-thirds of the voting members of the House of Delegates vote approval and provided that it shall have been published twice during the year in *The Journal* of the Association.

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The Woman's Auxiliary Reports to ISMA

On April 20-22 the scene of activity was at the Marriott Inn in Clarksville during our 32nd Annual House of Delegates. Business was mixed with pleasure. One of the highlights was having our AMA Auxiliary president, Mrs. Erle Wilkinson, join us. In her address she shared the following remarks:



"All of us realize that the world has changed — and rapidly. This applies to our Auxiliary.

"We've undergone change in order to keep up with the times. We're moving in new directions. We **must,** because as each day passes we're faced with new challenges.

"Crises face the medical profession — national health insurance, malpractice insurance, health maintenance organizations. We, as doctors' wives, must face these problems and help maintain the ideals which make the medical profession sound and honorable."

Mrs. Wilkinson stated that **now is the time to think unity.** "For now, more than ever, unity is the one thing that will help us accomplish our goals. The point of belonging to any organization is to benefit from others' thinking and potential. We must recognize the talents and contributions of individuals; but we must also recognize that it is the unity of individuals, group action, which gets things done. A small but steady increase in national membership has been seen. It shows that doctors' wives across the country want to be involved in our programs. They want to give **legislation aid to medicine, raise funds for medical education,** and **work for improved quality of life** in their communities." Mrs. Wilkinson went on to say,

"In the past year alone, in auxiliaries across the country, we have had **194 immunization programs, 172 blood donor programs,** as well as programs built around **nutrition, child abuse, parenting,** and **safety.**
These figures only scratch the surface in terms of people helped and work accomplished."

"Go out and tell the real story of medicine, won't you? Inform yourselves on the problems which face organized medicine and become a spokeswoman for your overworked husband. Your friends and acquaintances will listen to you, because by a sort of osmosis you are also a medical authority. Bring in new members to swell the ranks. Remember, in unity we have strength. Through the strength of our unity we have a voice."

Let's be involved, and let's involve others! We can do **more** together.

Chloe A. Goldsmith

Chloe (Mrs. David A.) Goldsmith
President, ISMA Auxiliary

News from CHAMPUS

To: CHAMPUS Physician Providers
From: James A. Waggener, Executive Director, ISMA CHAMPUS Division
Subject: CHAMPUS Reimbursement

Important that you be aware of a directive from the federal level regarding claim reimbursement for CHAMPUS beneficiaries.

Effective 1 July 1976, State Fiscal Administrators have been instructed to, in effect, use the Medicare reimbursement program for payment of CHAMPUS claims. This reimbursement schedule drops to payment on the 75th percentile based on 1975 fees. A superficial estimate of the effect of this change may mean a reduction in the amount which CHAMPUS can pay for many procedures.

Beneficiaries of the CHAMPUS program may file their own claim in which the amount is substantiated by an itemized statement of fees and supported by evidence of payment. Eligible costs will then be reimbursed to the beneficiary in accordance with CHAMPUS profiles. Providers are herewith reminded that in this instance Item 20 on the claim form should *not* be signed.

Please note that the normal ending date of 30 June 1976 for required deductibles will be extended through 30 September 1976, in order to conform to the new federal fiscal year.

Your past cooperation and participation in the CHAMPUS program is appreciated. It is hoped that the federal establishment will eventually recognize the disparity between the groups which participate in CHAMPUS and Medicare and thus improve the CHAMPUS program.

About Our Cover

It doesn't take a rocket ship to reach Camp Riley for Physically Handicapped Children, yet upon arrival it is like stepping into the camp of the future, a camp "20 years ahead of its time." It is owned and operated by the James Whitcomb Riley Memorial Association.

For the past 21 years more than 4,500 handicapped children have gone to Camp Riley for "the time of their lives," to hike, swim, fish, explore and to learn to venture out on their own and realize that their capabilities stretch further than they thought.

More than a million dollars worth of construction the past 18 months has created one of the most outstanding camps of its kind in the United States. A new dining hall, arts and crafts center, nature center, outdoor swimming pool, trails and bridges have been constructed this year. Six lodges, nature trails, bathhouse, special pier for wheelchair fishermen and bathing beach were built last year.

Camp Riley is located north of Martinsville in a 2,300-acre wooded area called Bradford Woods, a gift from John Bradford and his two brothers for the use of all Indiana children.

The camp program was originally planned as an extension of rehabilitative service to patients from James Whitcomb Riley Hospital for Children. It has been broadened to include any physically handicapped child, age 8 through 18, approved for a camping experience by his family physician. A large number of campers obtain their camp applications from their doctors.

Camp Riley and its program have been developed and maintained by the Riley Memorial Association with the invaluable cooperation of Indiana University recreation leaders and staff of Riley Hospital. The buildings, equipment, supplies, program development and operation have been made possible by gifts through the Riley Memorial Association from hundreds of Indiana citizens working as individuals or in groups.

Dr. Joseph M. Black of Seymour, a member of the Riley Memorial Association Board of Governors, says "Camp Riley is a special place for special people. Here there are opportunities for self-improvement. They may learn new uses for twisted hands, discover a latent talent, or even enjoy a reprieve from television which, too often, is the center of attention for physically handicapped children. Here, they become doers instead of dreamers. This is the mission of Camp Riley."

As many as 45 handicaps such as muscular dystrophy, hemophilia, cystic fibrosis, blindness, myelomeningocele, cerebellar degeneration, congenital abnormalities and accidents are represented among the campers. Wheelchair campers might be able to shuck an ear of corn for a cook-out, or enjoy swimming, wheelchair dancing or fishing. Blind children are able to join in crafts, cooking or other activities with appropriate descriptions and guidance from the counselor.

Emphasis at camp is on outdoor education and personal growth, but "just plain fun" is never forgotten, notes Omer H. Foust, executive director of the Association. — **N.C.**

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FUTURE MEETINGS, SEMINARS, COURSES

Seventh Family Medicine Review

Two identical sessions will feature the University of Kentucky's Seventh Family Medicine Review.

The first is scheduled to be held Sept. 26-Oct. 2, and Session II will be held Oct. 17-23 at the UK Medical Center, Lexington. Registration fee is $295. Further information may be obtained from Frank R. Lemon, M.D., Continuing Education, University of Kentucky College of Medicine, Lexington 40506.

Richter Lectureship at St. Vincent Hospital

The second annual Richter Lectureship will be held at St. Vincent Hospital on Wed., Sept. 29. The program will be an all-day affair with Dr. Harold D. Levine, associate clinical professor of medicine, Harvard Medical School, as guest speaker. For further information contact the Medical Affairs Office, St. Vincent Hospital, 2001 West 86th Street, Indianapolis 46260; 317-871-2345.

Hoosiers on Symposium Faculty

Drs. James E. Bennett, James W. Strickland and James B. Steichen, Indianapolis, are members of a faculty for a symposium on "The Management of Hand Injuries" which is sponsored by the American Society for Surgery of the Hand. The meeting will be at the Drake Hotel, Chicago, on Oct. 7, 8 and 9. Specialists from Chicago and nationally will discuss all aspects of hand injury. Tuition for physicians is $200, for residents $100. Write John L. Bell, M.D., 767 N. Fairbanks Court, Chicago 60611.

Tumor Localization Kentucky Subject

"New Methods in Tumor Localization" is the subject of the seminar announced by the University of Kentucky Medical Center for Oct. 7-9 at Lexington. For further information, contact Frank R. Lemon, M.D., College of Medicine, University of Kentucky, Lexington 40506.

Medical Assistants to Meet Oct. 10

The Indiana Society of the American Association of Medical Assistants will conduct its Third Annual Medical Assistants Day on Sun., Oct. 10, at the Indiana State Medical Association Convention. The event will be at the Indianapolis Hilton Hotel and will consist of an all-day seminar on the subject "Cancer: A Team Approach." All those interested should register, before Sept. 27, with Ms. Bonnie Reidenbach, 318 E. Washington St., Bluffton 46714.

Common Neoplasms Subject of Seminar

Northwestern University Cancer Center will present the Second Annual Postgraduate Seminar in Oncology, The Management of Common Neoplasms: Head, Neck, Gynecological and Urological Tumors, Oct. 21-23, 1976, at Northwestern Memorial Hospital, Passavant Pavilion, Offield Auditorium, 303 East Superior St., Chicago, Illinois.

Fee for the 2½ day Conference will be $150 for practicing physicians; $75 for Fellows and house officers.

Registration is limited to 100 applicants.

Questions regarding the conference may be addressed to John S. Schweepe, M.D., Northwestern University Cancer Center, 303 East Chicago Ave., Chicago 60611, or telephone 312-642-9294.

Urgent and Controversial Pediatric Conditions Subject of Symposium

A symposium on urgent and controversial pediatric conditions will be held at Stouffer's Indianapolis Inn on Oct. 26 and 27 under the sponsorship of the I.U. School of Medicine and The James Whitcomb Riley Hospital for Children.

Visiting faculty include Dr. Jay M. Arena, Duke University; Dr. Samuel Kaplan, University of Cincinnati; Dr. Alfred A. deLorimier, University of California at San Francisco, and Dr. Robert Soper, University of Iowa.

Topics include: respiratory distress syndrome, poisoning, congenital heart disease, diaphragmatic hernia, congenital hip, urinary tract infection, gastro-intestinal bleeding, neonatal sepsis, hemolytic anemia, biliary atresia, esophageal atresia, inflammatory bowel disease, gastroesophageal reflux.

(Approved for 13 hours postgraduate credit AMA.)

For further information concerning registration contact Jay L. Grosfeld, M.D., surgeon-in-chief, or Morris Green, M.D., physician-in-chief, Riley Hospital, 1100 W. Michigan St., Indianapolis 46202.

Breast Cancer Detection Foundation Announces Second Annual Symposium

The Second Annual Mid-American Breast Cancer Symposium, to be held at Madison, Wis., under the sponsorship of the Wisconsin Breast Cancer Detection Foundation, Nov. 5-6, will honor Dr. Robert Egan, pioneer mammographer.

There will be workshops on screening, thermography, mammography, xerography, pathology and surgery, and the following speakers will be featured: Drs. Robert Hutter, Ray Lawson, Myron Moskowitz, Harold Isard, Phillip Strax, C. B. Esselwyn, N.J.M. Aarts and Egan.

Twelve hours credit in category 2 for the AMA Physician's Recognition award.

Write 7803 Mineral Point Road, Madison, Wis. 53717, or call 608-831-2300.

Symposium on Polytomography Of Temporal Bone Announced

The 15th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, on Nov. 6 and 7, 1976. This continuing Medical Education activity is acceptable for 12 credit hours in Category 1 for the AMA Physician's Recognition Award (PRA).

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technic of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on origi-

nal tomograms and the clinical applications discussed.

Number of registrants is limited to 20. Fee for the course is $250.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis, 46219.

61st Annual Scientific Assembly Set

The Postgraduate Medical Association of North America will conduct its 61st Annual International Scientific Assembly at the Atlanta Marriott Hotel Nov. 15 to 18. The program is designed for Primary Care Physicians of United States and Canada. It provides 21 hours of prescribed and 3 elective hours of credit for members of the American Academy of Family Physicians. The Assembly is open to any licensed physician at a fee of $50 in advance or $75 at the meeting. Write Alton Ochsner, M.D., P.O. Box 1109, Madison, Wis. 53701.

Midwinter Conference at St. Croix

The second Mid-Winter Virgin Islands Clinical Conference will be held in St. Croix, Jan. 13-15, 1977, by the U. S. Virgin Islands Medical Society in association with The Faculty of the University of Pennsylvania School of Medicine.

This program is acceptable for 14 credit hours in Category 1 for the Physician's Recognition Award of the AMA, and will include lectures and seminars of interest to the physician in General Practice, Internal Medicine, General Surgery, OB-Gyn and Pediatrics.

For further information, write AIRMAIL to: James S. Glenn, M.D., F.A.C.P., Chairman, U.S. Virgin Islands Medical Society, P.O. Box 520, Christiansted, St. Croix, U.S. Virgin Islands 00820.

Aspen Radiology Conference Set

The Seventh Annual Aspen Radiology Conference, which will cover diagnostic radiology, nuclear radiology and diagnostic ultrasound, will be held Feb. 28 to Mar. 4, 1977, at the Aspen Institute for Humanistic Studies, Aspen, Colorado. For full information write Emanuel Salzman, M.D., Beth Israel Hospital, Denver 80204.

Workshop on Issues in Primary Care

"Issues in Primary Care" will be the subject of the 1976 Workshop of the Institute of Medicine of Chicago, to be held at the Continental Plaza Hotel on Dec. 3 from 8 a.m. to 5 p.m. Registration includes luncheon. For full information write the Institute at 322 S. Michigan Ave., Chicago 60604.

Neurological Society Meeting Dates

The Fall 1975-Spring 1976 meetings of the Indiana Neurological Society will be on the following dates at the Athenaeum in Indianapolis at 7 p.m.—Nov. 19, Jan. 18, Mar. 18, May 20.

Further information as to programs, speakers, etc., may be obtained by calling James May, executive secretary, Indiana Neurological Society, Emerson Hall 125, 1100 W. Michigan St., Indianapolis 46202, 264-8000.

Notice to Indiana Physicians

Clinical research is in progress at the Indiana University School of Dentistry in the bleaching of tetracycline stained teeth, discolored teeth affected with fluorosis and other causes of tooth discoloration.

The Endodontic Department would be pleased to cooperate with patients so affected and they could be referred to their family dentist or the Endodontic Department would be pleased to assist in treating such patients.

For examination, please call 264-2403, Department of Endodontics, Indiana University School of Dentistry, 1121 W. Michigan St., Indianapolis 46202.



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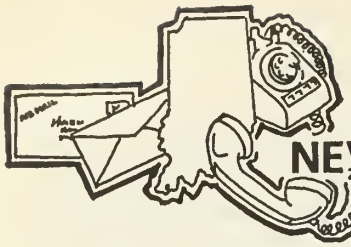
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NEWS NOTES

Erratum

The Journal regrets that the following name was omitted from the 1976 Roster of Members:

McCallister, John W. (GS) 3124 East State Blvd., Fort Wayne 46805.

Dr. Eskew Elected to Head JFCAC

Dr. Philip N. Eskew, Jr., Indianapolis, has been chosen Chairman of the Junior Fellow College Advisory Council of the American College of Obstetricians and Gynecologists.

Medical Film Festival Entries Wanted

The American Medical Writers Association announces that entries are now being accepted for judging in its Third Annual Medical Film Festival. Producers of medical films for both professional and lay audiences are invited to submit their entries to: F. M. O'Rourke, Film Program Chairman, 1300 N. Vermont Ave., Los Angeles, CA 90027.



Med Center to Get Certification Registry

The Indiana University Board of Trustees recently approved an agreement allowing the American Board of Obstetrics and Gynecology to establish a central certification registry at the I.U. Medical Center in Indianapolis. The University will provide space, staff and services for the certification program for more than 14,000 diploma holders in the United States.

Dr. Charles A. Hunter, Jr., chairman and professor of obstetrics and gynecology, and Dr. Jack W. Pearson, vice chairman of the department, were instrumental in developing and planning the new computerized operation. Dr. Hunter was elected secretary of the Board and Dr. Pearson was elected assistant secretary, both for 10-year terms.

Story Features Two Hoosier Physicians

Two physicians were featured in an article in The Indianapolis Sunday Star recently: **Dr. H. P. (Bud) Graessle, Seymour,** and **Dr. Harvey Middleton, Indianapolis.** The article was part of a special Bicentennial issue and was built around the premise that the past 200 years are reflected in the present and included "a sampling of modern Hoosiers from every corner of the state."

Dr. Jacqmain Receives Award

Dr. Ralph Jacqmain, Vincennes, received the "outstanding physician award" presented by the Knox County PAP Clinic for "outstanding promotion and encouragement" of the recent clinic. Previous award winners are **Dr. Louie Dayson** and **Dr. Jack Shanklin, both of Vincennes.**

On Athletic Training Workshop Program

Among Indiana physicians who participated in the three-week seminar on Sports Medicine for the Physician and Athletic Trainer that was held at Terre Haute in July were **Drs. Robert Burkle, Terre Haute,** and **Dr. Henry Feuer, Indianapolis.**

Diabetes Detection Program Wins Award

Dr. Leon L. Blum, Terre Haute, was one of those honored recently at the annual meeting of the American Diabetes Association, Indiana Affiliate. He represented the Terre Haute Medical Laboratory, which, along with Union Hospital, received the Program Award for the state's first in-hospital diabetes detection drive, conducted last November and currently being used as a model for ADA chapters around Indiana.

Dr. Sinn Addresses Medical Assistants

Dr. Charles Sinn, Evansville, was guest speaker at the June meeting of the First District Medical Assistants, Indiana Society, AAMA.

Dr. Lucas Named to PSRO Council

Dr. William F. Lucas, Indianapolis, has been named a member of the National Professional Standards Review Council of the United States Department of Health, Education, and Welfare. He serves as vice-president of Utilization Review for Blue Cross and Blue Shield of Indiana.

The council is charged with developing national programs to monitor the quality and necessity of health care delivered in medical institutions receiving federal funds.

Continuing Medical Education

Among the Hoosier physicians who earned the AMA Physician's Recognition Award in June were the following:

Drs. Clayton Hugh Atkins, Greenwood; Adel Habib Ayoub, Valparaiso; James Ferguson Balch, Indianapolis; Milton Lewis Bankoff, Michigan City; Fred Mayor Blix, Indianapolis; Leslie Eugene Bombar, Munster; Harvey J. Brechtl, South Bend; George Michael Buehler, Jeffersonville; Donald Clemens Buehner, Evansville, and **Rudsen M. Bueser, Vincennes.**

Also, **Drs. James V. Cortese, Indianapolis; Clifford Lindley Craig, Lafayette; Jay S. Fleishman, Kendallville; Francis Hugh Gootee, Jasper; Martin J. Graber, Beech Grove; Morgan E. Greene, Indianapolis: Samuel D. Hennessee, Carmel; Thomas H. Hollingsworth, Muncie; Olegario J. Ignacio, Jeffersonville,** and **Richard Stephen Irwin, Roachdale.**

Additional June winners are **Drs. Cesar Canonigo Labitan, East Chicago: Ivan T. Lindgren, Aurora; Dean Lloyd Mattox, LaGrange; Thomas O. Moore, Indianapolis; John Henry Nill and Charles August Novy, Fort Wayne; Francis W. Price, Indianapolis; Antone Charles Remich, Hammond; William R. Stilwell, Richmond; Robert Henry Terry, Boonville,** and **Alan Willner, Clarksville.**

Named as Consulting Editor

Dr. J. Wei-Ping Loh of Gary has been invited and appointed to serve as a consulting editor for "U.S. Physicians International," a medical journal for physicians who have international background. The journal is published in New Jersey and has circulation in the U.S. and foreign countries.

Speaks at Philippine Medical Meeting

Dr. Frank Wu, Indianapolis, was one of the speakers at the regional session of the Indiana Philippine Medical Association held in Indianapolis on July 18. His topic was "New Therapeutics for Bronchial Asthma."

Named Columbia City Citizen of Year

Dr. Otto F. Lehmberg, Columbia City, was honored at a recent meeting of the area's Chamber of Commerce when he was awarded a bronze plaque and named "Citizen of the Year" for his outstanding service to the community. Dr. Lehmberg retired from the practice of medicine at the end of June.

Named Secretary-Treasurer by Two Groups

James A. Waggener, executive secretary emeritus of ISMA, was chosen recently at the Dallas meeting of the AMA as secretary-treasurer of two medical organizations: the Forum of Medical Affairs, which conducts an open meeting for all attendees at the AMA Convention, and the Association of Presidents and Other Officers of State Medical Associations.

Dr. Steen Re-elected AMA Trustee



At the AMA's 125th Annual Convention in Dallas in July, **Dr. Lowell H. Steen, Hammond,** was re-elected to the Board of Trustees. Dr. Steen was also elected vice president of AMA-ERF.

Dr. Richard E. Palmer, Alexandria, Va., was installed as the AMA's 131st president; Dr. John H. Budd, Cleveland, was named president-elect, and Dr. F. T. Holland, Tallahassee, Fla., was elected vice president.

Dr. Raymond T. Holden, Washington, D.C., was re-elected chairman of the Board of Trustees.

November 1972 Journal Wanted for Museum

A copy of the November 1972 issue of *The Journal* is wanted by the Brown County Historical Society to display in the pioneer physician's office of Dr. Alfred Ralphy which has been moved to the Nashville Town Square and restored. Reminiscences of Dr. Ralphy's practice in Nashville and New Bellsville were featured in that issue and on the cover.

Anyone who can supply this issue may call or write *The Journal,* 3935 N. Meridian St., Indianapolis 46208; 317-925-7545.

New Insurance Firm Organized

A new medical malpractice insurance company has been organized in Indiana.

The Physicians and Surgeons Liability Insurance Company, Inc., of Munster, has recently received its certificate of authority to write malpractice insurance for Indiana physicians.

The company, owned and operated by Indiana physicians, was established to fill the void created by the departure of regular carriers in this field.

The address is: 800 MacArthur Blvd., Munster 46321.

Mosquito Council Set Up

Gov. Otis Bowen has appointed three physicians to an ad hoc advisory council to coordinate intensified mosquito control programs: **Drs. Wilson Dalton, Shelbyville,** representing the Indiana State Medical Association; **Dr. Robert Seibel, Nashville,** representing the Indiana Association of Public Health Physicians, and Dr. Charles Barrett, Indianapolis, director of the Communicable Disease Control Division, State Board of Health.

Railroad Medical Officer Retires

Dr. Howard B. Hamilton, Indianapolis, retired from the practice of medicine recently after 36 years with the Pennsylvania and Penn-Central railroads, the last 15 as divisional medical officer at Indianapolis. Some years earlier he was in the railroad's medical department at Terre Haute for a time.

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BOOK REVIEWS

NEWLY REVISED INDIANA DIET MANUAL

The *Indiana Diet Manual* has been completely revised this year and is presently being distributed. It has been approved by the Indiana State Medical Association, the Indiana Dietetic Association, the Indiana Hospital Association and the Indiana State Board of Health.

The Manual has been prepared for use in health care facilities and is intended to be a guide for physicians to use in prescribing modified diets and for personnel in health care facilities to use in interpreting and following physicians' orders.

The Manual provides information on modifications in consistency, fat, calories, sodium and protein—diets required for the treatment of such conditions as diabetes, hypertension, ulcer, diverticulosis and obesity. The appendix has been expanded and contains information including the nutritional analysis of commercial feedings and a reference to drug-food interactions.

All information is based on scientific investigation and reflects a trend in the liberalization of modified diets. Diets no longer considered appropriate for current nutritional management have been deleted.

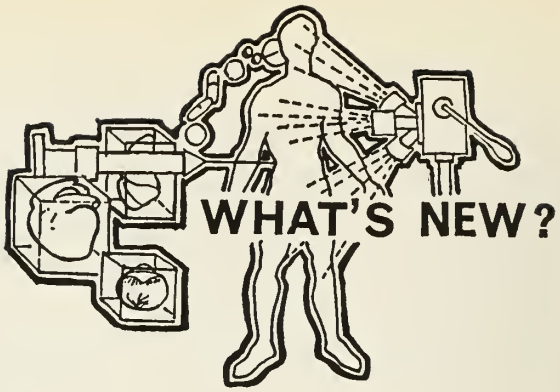
For further information regarding the Manual, write to: Indiana Diet Manual Committee, 809G Lincolnwood Lane, Indianapolis 46260.

MEDIX TV PROGRAMS FOR 1976: WHEN MINUTES COUNT • A GIFT OF LIFE • RELAX—TAKE IT EASY • SEXUAL COMMUNICATION • A GOOD SPORT • INFERTILITY • PLASTIC SURGERY FAMILY ALCOHOLISM: THE BIG SPILLOVER • IF ATTACKED • TAKING THE "DIE" FROM DIABETES CRIB DEATH: THIEF IN THE NIGHT • BREATHING MADE HARD • POISON • BIO-FEEDBACK: WAVES OF THE FUTURE • STRIKE BACK AT STROKES • WAYS TO WEIGH LESS • FIRST AID, SECOND NATURE • AGE IS JUST A NUMBER CHILDBIRTH, THE NATURAL WAY • PROFILE: THREE NURSES • IS THERE A BETTER WAY OF DYING? • CHILD ABUSE: THE MONSTER INSIDE ME • HUMAN SEXUALITY • MAMA NEVER TOLD ME ABOUT VD • LUPUS: WOLF IN DISGUISE

MEDIX

award-winning TV health-care documentaries prepared in conjunction with the Los Angeles County Medical Association and endorsed by 300 medical societies across the country

consult local listing for time/channel



Endo Laboratories has introduced VALPIN® 50 (anisotropine methylbromide 50 mg) and VALPIN® 50 PB (anisotropine methylbromide 50 mg with phenobarbital 15 mg) to provide increased antisecretory and antispasmodic pharmacologic action.

* * *

Orthopedic Equipment Company of Bourbon, Ind., has a new tubular pressure bandage system. It is constructed of cotton-covered elastic threads woven into a strong, circular, double knit fabric to produce controlled elastic tension and even, constant pressure with comfort.

* * *

Ames announces a new screening test for urinary infection. MICROSTIX®-NITRITE reagent strips provide a dip-and-read test for nitrite in urine. Positive result indicates bacteriuria. It is especially useful in detecting asymptomatic bacteriuria. The test may be performed at home.

* * *

Schering has introduced a new product for the treatment of bronchial asthma. Called Vanceril Inhaler (beclomethasone dipropionate), it has been used internationally for more than three years. The inhaler provides treatment of the inflammation and edema of the lungs caused by chronic asthma.

* * *

The 3M Company announces availability of sterile applicator ampoules of tincture of benzoin designed for painting the skin immediately prior to applying Steri-Strip adhesive wound closures. Adhesion is greatly improved and the applicator ampoules make it possible to coat the involved skin without contaminating the wound.

* * *

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical labaratary supplies, instruments and surgical appliances—and baok publishers. Each item is published as news and daes nat necessarily canstitute an endarsement of a praduct ar recammendation for its use by THE JOURNAL or by the Indiana Stata Medical Association.

Art, Hobby Show Planned For ISMA Annual Meeting

Space will be provided at the 1976 annual meeting of the Indiana State Medical Association, Oct. 10, 11 and 12 at Indianapolis, for an Art and Hobby Show.

Members of the ISMA and their wives are invited to participate. Information regarding this year's show may be obtained from:

Indiana State Medical Association
3935 North Meridian Street
Indianapolis 46208

It will be the responsibility of each exhibitor to see that his work gets to and from the Indianapolis Hilton, Ohio and Meridian Streets, Indianapolis. (The final arrangements will be provided by the committee.)

IT WILL BE NECESSARY THIS YEAR FOR EACH HOBBY SHOW PARTICIPANT TO BREAK DOWN HIS EXHIBIT EACH EVENING FOR SECURITY REASONS. LOCKED STORAGE SPACE WILL BE AVAILABLE.

ISMA will provide suitable display facilities, but each exhibitor is responsible for transportation costs or any other such expenses involved in entering his exhibit.

In order that the committee may do its best in fulfilling the needs of your exhibit, it is ESSENTIAL that you accurately indicate below the amount of space required for your exhibit.

All exhibits must be labeled with your name and address and each should be titled.

We do not encourage rare or valuable exhibits, because their safety cannot be insured.

In order that the committee may be adequately prepared for your exhibit, **ALL** applications must be submitted no later than Sept. 27, 1976.

We solicit your exhibit to make this year's show the most successful.

APPLICATION for SPACE in ART and HOBBY SHOW

Exhibitor _____ Total number items to be exhibited _____

Address _____

Telephone No. _____

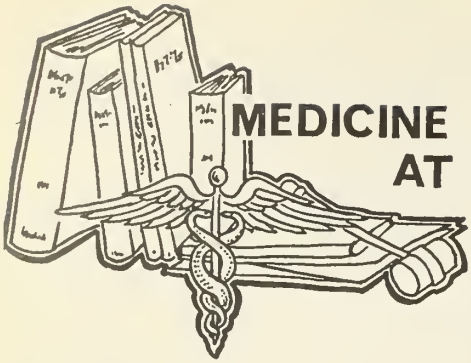
CATEGORY*	TITLE	SIZE or SPACE REQUIRED

MAIL TO:

Indiana State Medical Association
3935 North Meridian Street
Indianapolis, IN 46208

DEADLINE for submission of application is SEPT. 27, 1976

* Please indicate whether your exhibit is oil, watercolor, photography, sculpture, or arts and crafts, etc.



MEDICINE AT LAW

Illinois Physician Wins Countersuit—In a landmark decision, a radiologist was awarded $2,000 in compensatory damages and $6,000 in punitive damages by an Illinois jury.

The radiologist, an orthopedic surgeon and a hospital were named as defendants in a malpractice suit. The patient and her husband sought $250,000 in damages, claiming that the defendants failed to discover a fracture in the patient's little finger and that as a result the finger has a lasting disability. The patient, who had injured her finger while playing tennis, claimed that the radiologist misread the hospital x-rays. The fracture was discovered in subsequent x-rays.

In the radiologist's countersuit against the patient, her husband and their two attorneys, the radiologist contended that the fracture did not appear on the first x-rays, through no negligence on his part or on the part of the hospital. He said that the treatment given the patient was the same as that given for a fracture.

Both the malpractice suit and the countersuit were to be tried together. The day after the jury was selected, the patient and her husband withdrew their malpractice suit. The radiologist continued with his suit, however. The orthopedic surgeon and the hospital did not join in the countersuit.

In his complaint, the radiologist charged that all four of the defendants were "guilty of willful and wanton conduct." He also contended that the attorneys were "negligent in fulfilling their duties as attorneys in investigating the malpractice suit before filing it."—*Berlin v. Nathan* (Ill.Cir.Ct., Cook Co., Docket No. 75-M2-542, June 1, 1976).

SCIENTIFIC EXHIBIT APPLICATION FORM

Committee on Scientific Exhibits
Indiana State Medical Association
3935 N. Meridian Street
Indianapolis 46208

Please send me an application form for a scientific exhibit at the ISMA Annual Convention, Oct. 9-12, 1976, at Indianapolis

I propose to exhibit _____

Name _____

Address _____

City, State and ZIP _____

Because of limited space the committee has set a limitation on scientific exhibits. Consequently, the committee will allocate space on a priority based on date of receipt of the application.

COMMERCIAL ANNOUNCEMENTS

DIRECTOR OF MEDICAL EDUCATION — Immediate opening in Big 10 University town. Responsible for continuing medical educatian for hospital staff and affiliated medical students. Part time private practice privileges. Salary negotiable. Send resume and curriculum vitae ta Office af Medical Educatian, Bloomington Haspital, P.O. Box 1149, Blaomington, IN 47401.

PHYSICIAN OPENING IN INDIANA REHABILITATION SERVICES INDIANA REHABILITATION SERVICES has openings for physicians in its variaus divisions. Interested persons should contact Dr. Walter E. Deacon, #1016 Illinois Building, 17 West Market Street, Indianapolis, Indiana, Telephone: 317-633-5961.

EXCELLENT OPPORTUNITY and environment—Physician needed to practice general medicine in large outpatient clinic and 38-bed fully accredited hospital. Must possess empathy toward college age population. Salary negatiable. Excellent fringe benefits. Contact L. W. Combs, M.D., Purdue Student Hospital, West Lafayette, Ind. 47907; 317-749-2441.

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FOR SALE: Doctor's office building. Also x-ray, Fischer ultrasonic generatar, ultraviolet lamp, cast cutters, splints, instruments and supplies. P.O. Box 37, Akron, Ind. 46910; 219-893-7117.

OPENING FOR PHYSICIAN with unlimited license to practice in Indiana, to fill vacancy of physician retiring after 16 years of service. Work with mentally retarded. Interesting and challenging! Forty-hour week plus "on call" night once weekly with one-half day campensatory leave; rotate weekend "on call" with full day compensatary leave. Many excellent fringe benefits. Will cansider physician on half time basis—mornings anly. Far applicatian cantact Gearge Smith, Personnel Director, Fart Wayne State Haspital and Training Center, 801 E. State, Fort Wayne, IN 46805; telephone 219-485-7554.

WANTED: A copy of the Navember 1972 issue of THE JOURNAL far the Brawn County Historical Society to display in the pioneer physician's affice af Dr. Alfred Ralphy which has been moved ta the Nashville Tawn Square and restored. Anyone who can supply this issue may call or write THE JOURNAL, 3935 N. Meridian St., Indianapalis 46208; 317-925-7545.

CUMBERLAND, IND. MEDICAL BLDG. For Lease. Deluxe one-story building under canstruction with passible laboratory facilities in lower level. Will divide and design to suit. Growing cammunity. Metra bus service. W. L. Garriott, Bldr.-Dev. 894-3158.

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A surgeon and pathalagists from Mankato and a radialogist fram Albert Lea make regular trips to the cammunity and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles).

Far additianal information, contact D. H. Gilbert, Wells Municipal Haspital, 400-4th Avenue, S.W., Wells, Minnesota 56097. (507) 553-5904 or 553-3111.

WANTED: Part-time position assisting Psychiatrist. Lang and highly regarded training and experience as Psychiatric Social Warker in psychiatric training centers—hospitals, clinics, and private practice. Understand insurance forms, community resaurces, etc. Impressive curriculum vitae an request. Edna Kelly, M.A., ACSW, phane: 259-4575 or address: 6206 N. Meridian West Drive, Indianapolis 46260.

PRACTICE FOR IMMEDIATE SALE located in tawn with an accredited haspital facility. Cantact Mrs. Richard G. Mehne, R.R. 11, Box 310, Brazil, IN 47834; 812-442-0491 or 448-1101.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

15¢ for each word
$3.00 minimum

Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

HELP FOR THE CONGENITALLY HANDICAPPED CHILD It wosn't so long ago that congenitally hondicopped children were ollowed to reoch school age or even loter before being fitted with o prosthesis. In recent yeors, experience hos shown that fitting ot on earlier age produces more effective results—both mentolly as well os physicolly. HANGER provides individually designed prostheses to give aid to the congenitally hondicopped child. Children with "HANGER PROSTHESES" con live normal lives. Using their HANGER appliances they exercise freely, ride bicycles, roller skote, ploy bosketboll, tennis, and engage in most of the activities like other growing children. These activities enoble the child to become self-reliant. Each HANGER prosthesis follows much the some design os those for the odult, but utilizes speciolly developed components of appropriote size, thus providing o smoother tronsition os the child grows into adulthood. HANGER olso provides devices ond techniques for the initiol fitting of infants ond problem coses. Training of chidlren in the use of their prosthesis is highly desirable, even though children present some problems not seen in adults. Since the ottention spon of young children is short, extreme potience is required. Some handicops make an ideol goit-pattern difficult if not virtuolly impossible to achieve. It should be noted that complete coaperation of the parent is necessary regordless of the experience ond ability of the theropist. (Often the parents poss on a sense of guilt that is completely unfounded as there ore no known preventive methods to combat the problem of o congenital handicap.)

Hanger PROSTHESES

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312 E. McMillan St., Cincinnati, Ohio 45219
416 N. Main Street, Evansville, Indiana 47711
3004 S. Wayne Ave., Fort Wayne, Ind. 46807

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Att'n: I. M. Wright

Sapphire Valley

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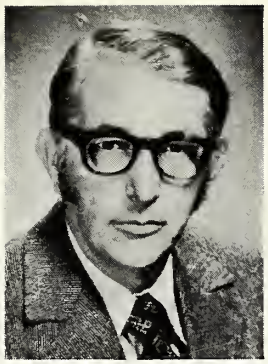
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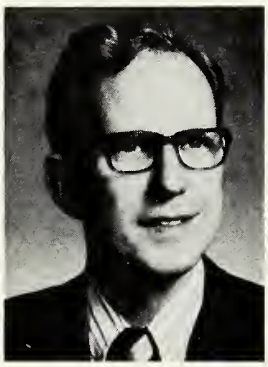
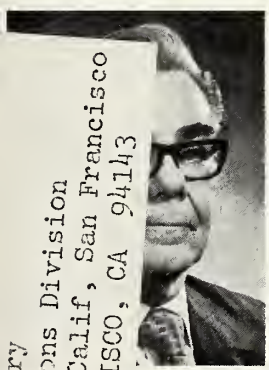
Upjohn Company, The 589

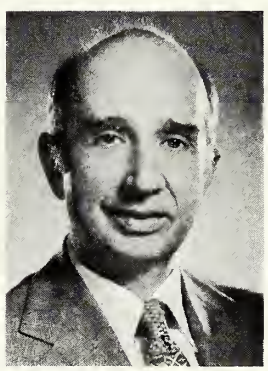
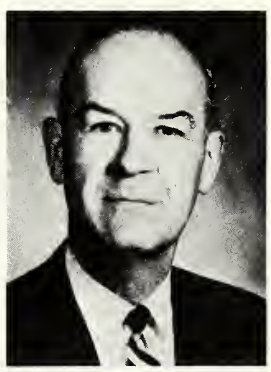
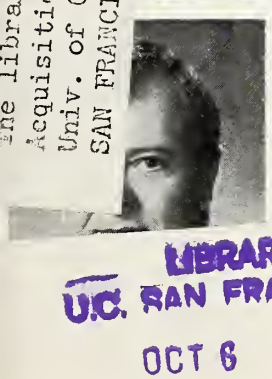
Yellow Cab Co. 559

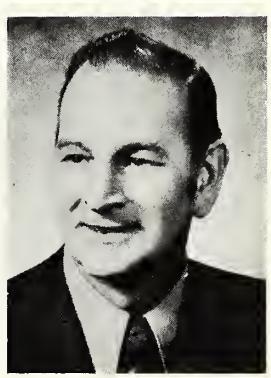
In accepting advertising for publication, THE JOURNAL has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.



The JOURNAL

OF THE
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Indianapolis

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

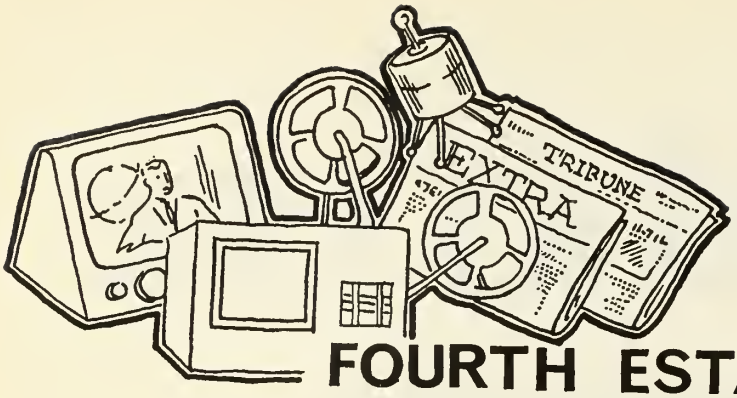
surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
Nutley, New Jersey 07110



FOURTH ESTATE

This section of THE JOURNAL is devoted to the presentation of opinions which appear on the editorial pages of the public press, and which are in interest to the medical profession. Its function is to review comments which may be favorable or unfavorable to medicine. Members are invited to submit editorial clippings for this column.

Television and the AMA

Policy-makers of the American Medical Association (AMA) have said in effect that television can be dangerous to health.

The AMA's House of Delegates decries violence on the tube as a threat to "the health and welfare of young Americans, indeed our future society."

One delegate said there is increasing evidence of a relationship between television crime and the recent upsurge in violent deaths among youths.

Some serious students of the problem feel that after continued exposure to TV violence, kids become morally calloused to the point where they no longer regard such acts as evil or criminal.

The AMA's new concern stems partly from a report in its journal that said the average 18-year-old American has spent more time watching TV than in the classroom. Before graduating from high school he sees 15,000 hours of television, witnessing 18,000 murders and countless incidents of robbery, arson, bombing, forgery, beating and smuggling.

And when he's doing that he isn't reading, getting outdoor exercise or doing anything else remotely worthwhile.

Now the AMA plans to publish a booklet for parents, urging them to be wary about what TV programs their children watch.

All of this has a familiar ring. More than 15 years ago, Newton N. Minow, then chairman of the Federal Communications Commission, shocked broadcasters by telling them that the world of television was "a vast wasteland."

Many viewers feel things have not changed much since then. To be sure, the networks have established a "family hour" for nonviolent shows before 8 p.m. But the effect has been less than satisfactory. Kids stay up after 8 p.m., it seems.

Naturally, parents can use their muscle to monitor what their kids see. But few do, more's the pity. And the violent shows are available with the click of a switch.

The AMA's delegates hope their campaign will have an effect on the commercial sponsors of crime shows by cutting into their audience ratings. Or by shaming them into refusing to have their corporate images linked with such trash.

A few great corporations do indeed sponsor some of the finer things that TV has to offer. If more of them were equally selective about where their TV money is spent, everyone would benefit, including the corporate images.

We hope the AMA succeeds where others have failed—*The Evansville Courier-Press,* July 18, 1976.



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Android®-10 Oral Tabs
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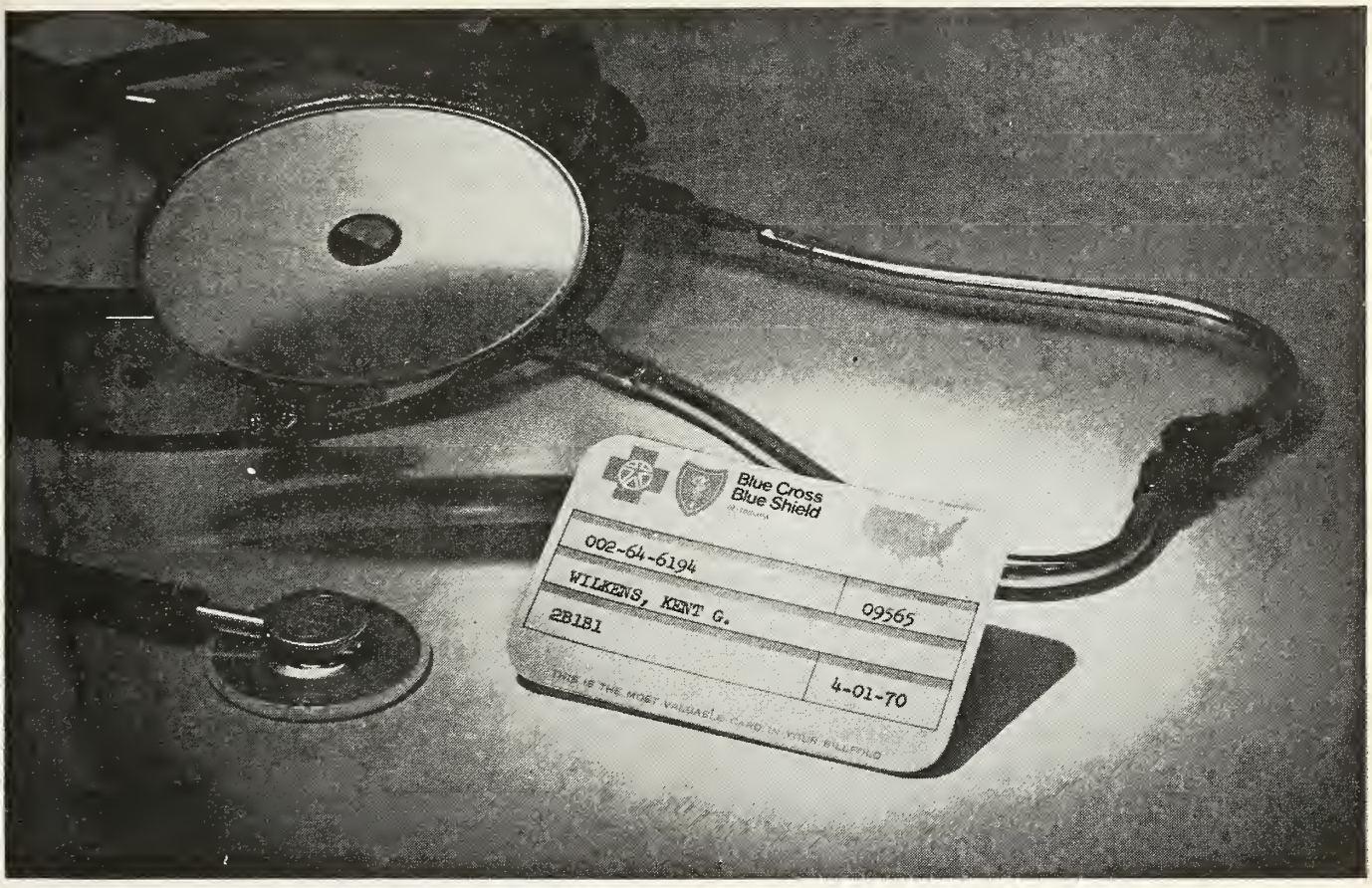
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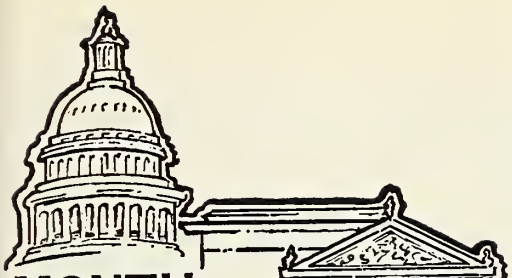
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

THE MEDICARE-MEDICAID COST CONTAINMENT BILL proposed by Sen. Herman Talmadge (D-GA.) could have harmful consequences on patients, the American Medical Association has told the Senate Finance Health Subcommittee.

The measure, introduced a year ago by Talmadge, was considered at a one-week hearing by the Subcommittee which the lawmaker heads. The wide-ranging bill contains scores of proposed changes in Medicare and Medicaid and calls for a major reorganization of the Government's health programs.

"In view of the continuing inflationary pressures in our economy, we are indeed sympathetic with the intent of this legislation to seek limitations upon the increasing costs of these health programs," testified Edgar T. Beddingfield, Jr., MD, chairman of the AMA's Council on legislation. He added, however, that "arbitrary curtailments of increases in costs will have natural consequences with respect to maintaining quality and availability of care. Each element cannot be treated separately without expectation of impact on the others."

"Taken as a whole, the bill should not be enacted as it would not be in the best interests of Medicare-Medicaid patients," said Dr. Beddingfield.

HEW Secretary David Mathews, testifying earlier, had said he was not confident the overall bill would be as effective as its backer hoped. He said he had "preliminary reservations." HEW's formal position on the bill will not be made "until the next budget-legislative cycle," Mathews said, adding there isn't time this year for Congress to complete consideration of the measure.

While there is little chance of the bill advancing in this Congress, Talmadge declared in an opening statement he hoped the hearings would provide the basis "for timely Congressional action."

Various restrictions, limitations and changes in reimbursement for hospital and physician services are among the controversial features of the bill.

One provision calls for creation of a "participating physicians" category under Medicare by which physicians would either accept on assignment all Medicare cases, or none. "Participating" physicians would be offered certain inducements, such as simplified and speeded-up billing procedures. After asking why more efficient payment procedures cannot be put into effect regardless, Dr. Beddingfield said "the fact that inducements are necessary in order to buttress a sagging assignment rate should cause an examination" of the current "insufficient reimbursement rate (which) is the major deterrent to assignments."

The purpose of the disputed provision would be better accomplished by "making the reimbursement level under that

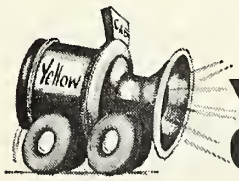
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system more acceptable and in accord with usual and customary practices," said the AMA official.

"The provision on 'hospital associated physicians' exceed the proper bounds of federal action," Dr. Beddingfield said. "It is not the role of the federal government to specify elements which constitute the practice of medicine generally or in any of its specialty fields. Nor should federal legislation, by statutory definition, attempt to divide or specify the role of the physician in the practice of medicine. Accordingly, the provisions as to anesthesiology services and pathology services should not be adopted."

He added that the section entitled "hospital associated physicians" is "misleading" and would apply to the entire spectrum of physicians' services in the Medicare program. "We strongly object to any application of any provision which would limit recognition of what constitutes physicians services in the communities across our nation. This section would disregard normal professional relationships and establish as the proper recognition of certain physicians' income only that level which would be received by a salary. We find this premise untenable."

The bill's ban on certain contractual relationships between hospitals and professionals was opposed by the AMA. "While some individual contracts are not to be condoned," Dr. Beddingfield said, "hospital management and physicians should be free to enter into various arrangements in the interests of patient care." Hospital management and physicians must remain accountable to the public, but the action of prohibiting any percentage arrangement "should not be countenanced."

The AMA spokesman said the bill carries "a very strong potential for a continued shifting of segments of health care costs to private patients—costs which are properly the obligation of the federal program on behalf of its beneficiaries. When this shifting occurs, it not only has ramifications relating to availability of care for Medicare-Medicaid patients, but it also affects quality of care for all patients.

PRESIDENT FORD HAS SIGNED LEGISLATION expanding the role of the National Heart and Lung Institute in blood diseases and resources. The Institute's name will be changed to The National Heart, Lung and Blood Institute to reflect the added responsibilities.

The law authorizes $339 million this fiscal year and $373 million for fiscal 1977 for the Institute, part of the National Institutes of Health.

Up to 30 research and demonstration centers will be established to conduct research, provide training and carry out demonstrations of advanced techniques of prevention, diagnosis and treatment. Ten centers will focus on heart and blood vessel disease; 10 on pulmonary diseases, and 10 on blood diseases, medical use of blood and blood products, and blood resource management.

The bill provides $40 million for prevention and control activities with special emphasis on cardiopulmonary and blood disorders.

UNDER NEW PROCEDURES ANNOUNCED by the Health, Education and Welfare Secretary, HEW must now consult broad segments of the public before it prepares controversial regulations mandated by Congress or for compelling administrative need.

The issuance of regulations by HEW over the past few years has become a subject of considerable dispute, with court challenges filed by the American Medical Association and others contending that the government had gone beyond the intent of Congress in carrying out the law.

"For far too long HEW has gone to the public in these situations only to tell them what it intends to do. From now on our first step will be to ask the people of this country what they think we should do," HEW Secretary David Mathews said.

The secretary said he believes strongly that the regulation process is HEW's "most intrusive channel into people's lives."

HEW will notify the public through town hall-type meetings, advertisements, public service announcements, news releases, professional and service organizations, mailings, the *Federal Register,* and HEW's 10 regional offices.

Following are the steps to be taken by HEW in drafting important regulations:

- **Publication of a notice of intent to propose regulations which would place issues and options before the public and invite comment.
- **If the Department has a preference, it will be stated clearly at the outset—an innovation.
- **Publication in the *Federal Register* of a notice of proposed rule-making—a proposed regulation—which takes into account the requirements of the law, Congressional intent, the public's views, and the professional expertise of HEW.

The public normally will have 45 days to comment following publication of both HEW's intent to regulate and its proposed regulations. Each of these documents will include the name of a person in HEW who can be contacted for clarification or further information.

HEW also said it plans training sessions for department regulation writers so that regulations are written in clear, concise English. ◄

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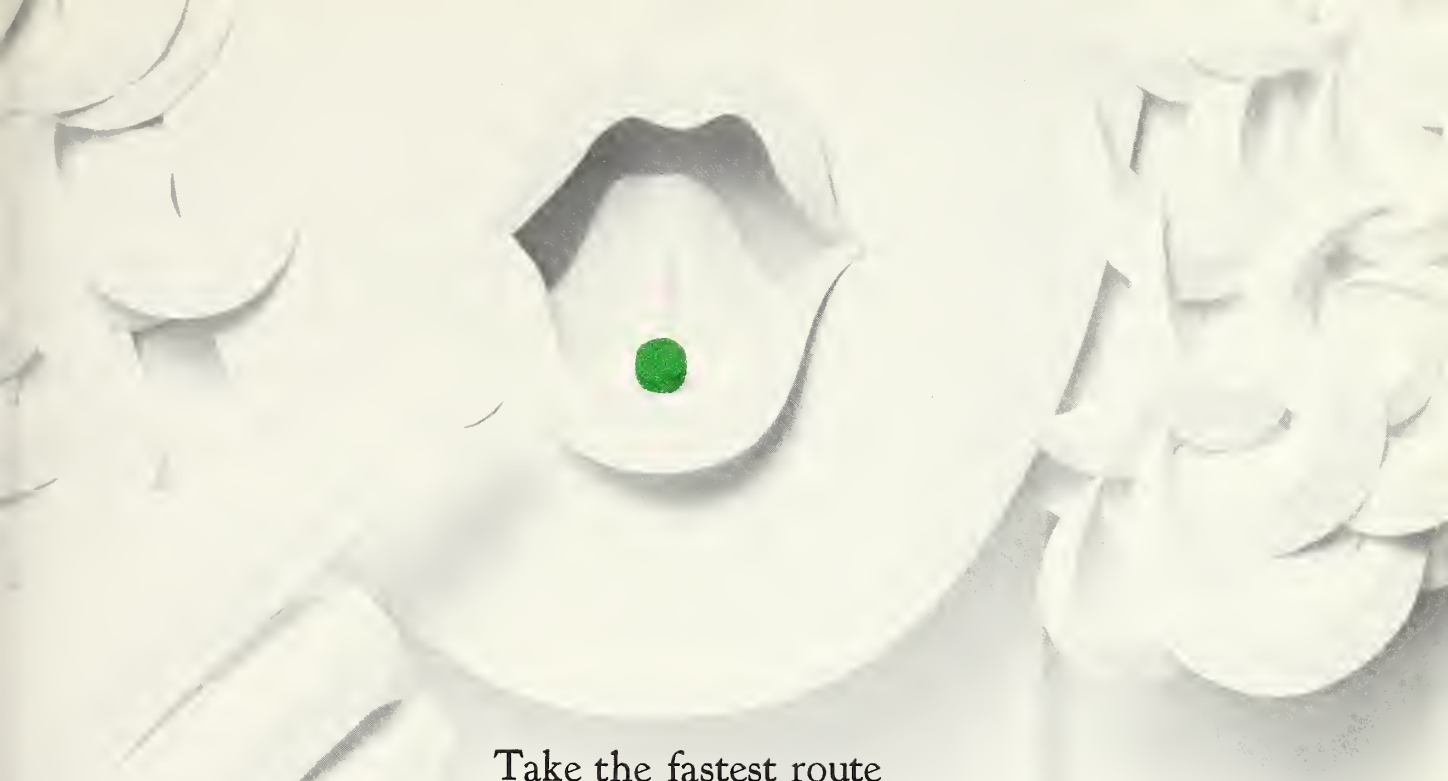
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1. Diamond S and Medina JL: Abortive therapy for vascular headaches. *Consultant* 16:156-165, 1976.

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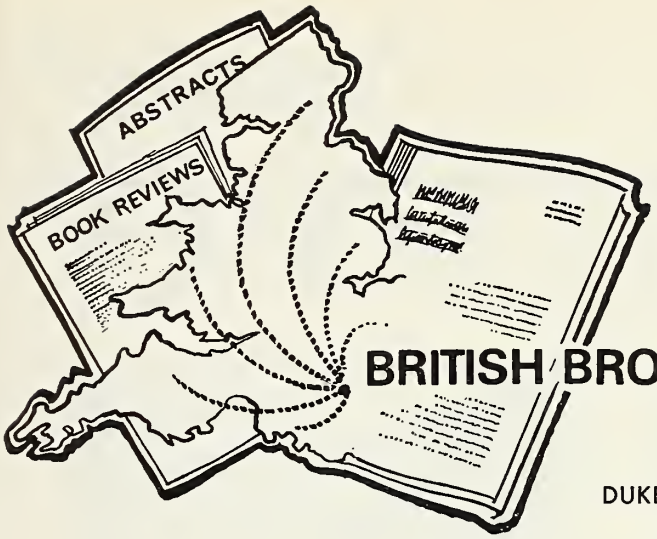
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Selections on Hypertension

Pathogenesis of Retinopathy

Sir Clifford Allbutt wrote in 1925 that "There are yield points in all structures, organic and inorganic, sound and unsound; beyond these their integrity is menaced or actually sapped." He was writing of the effects of hydrostatic pressure on the cardiovascular system. In an editorial in the *British Medical Journal* reviewing the pathogenesis of hypertensive retinopathy it is stated that "The retinal appearances of malignant hypertension are those of a vascular bed whose yield point has been reached and passed. The presence of cotton-wool spots and haemorrhages, with or without papilloedema, is the clinical evidence in a hypertensive patient that acute and progressive damage is occurring in the microcirculation. These changes can be reversed only by lowering the arterial pressure."

Following a brief review of recent research on the pathogenesis of hypertensive retinopathy the editorial writer states "Whatever the details of pathogenesis, it is now clear that the retinopathy of malignant hypertension results from extensive arteriolar and capillary damage through pressure. The cotton-wool spots are regions of the nerve-fibre layer rendered ischaemic by arteriolar closure. The linear haemorrhages in the nerve-fibre layer presumably arise from similarly damaged vessels. Papilloedema appears to result from local vascular damage in the nerve head, similar to that seen in the retinal vessels."[1]

Measuring Blood Pressure

Another editorial in the *British Medical Journal* reviews the need for a standard routine for measuring the blood pressure. The article comments on type of equipment, comfort of the patient and cuff size.

As to the actual measurement, the British writer says "Blood pressure is measured by auscultation of the Karotkoff sounds as the pressure in the cuff falls. The cuff should fit snugly, since pain from too tight a cuff will provoke a rise in pressure. Prolonged venous occlusion from repeated inflation may cause error. The arm should rest at heart level. Preliminary assessment of the systolic pressure by palpation of the radial artery will allow the cuff pressure to be raised to 30 mm Hg above the systolic pressure before auscultation begins. Cuff pressure should then be reduced by 2-3 mm Hg with each beat, and the appearance of the Karotkoff sounds (phase I) gives the systolic blood pressure. The best diastolic value is obtained as the Karotkoff sounds become muffled (phase IV); this criterion is now recommended even in the USA, but continued use of the previously recommended criterion of disappearance of the sounds (phase V) still causes some confusion."[2]

General Practice Observed

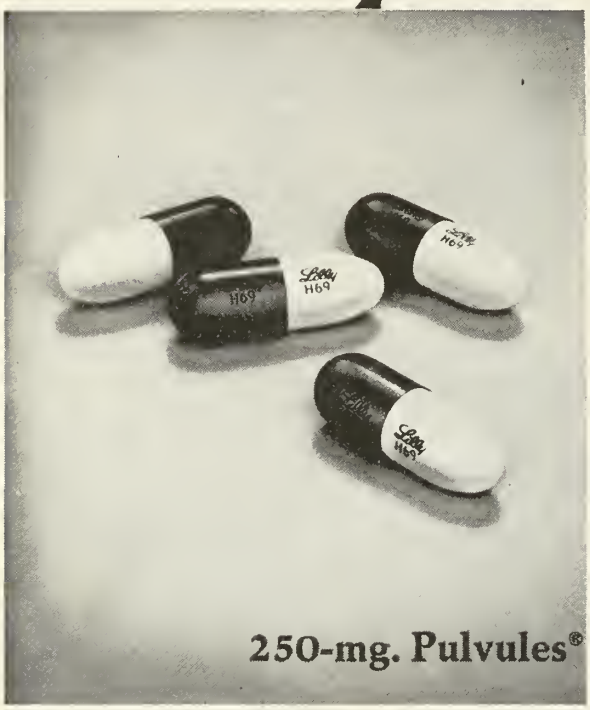
In an article from the London School of Hygiene and Tropical Medicine, the authors review a questionnaire sent to a 10% random sample of general practitioners in England and Wales on their attitudes to the detection and treatment of hypertension; 62% responded and no further inquiry was made. Their views on detection and criteria for treatment and investigations performed were considered in relation to their background.

The authors found "More of the older general practitioners always measured blood pressure and 36% of all practitioners believed that hypertensive patients usually present with symptoms. Altogether 91% thought that strokes could be prevented by treating hypertension, and only 18% reported difficulty in keeping patients on treatment. Older practitioners preferred to measure the diastolic pressure using phase V, while the younger preferred phase IV. Nearly all doctors were satisfied with their current sphygmomanometers."[3]

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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Fetal and maternal cells may be distinguished.

Prenatal Diagnosis of Fetal Abnormality by Amniocentesis

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CATHERINE G. PALMER, Ph.D.
JOSEPH THOMPSON, M.D.
ROSALIE ARMSTRONG
Indianapolis

Introduction

The fear of delivering a deformed or mentally retarded child is always present during pregnancy. Until several years ago, the diagnosis of fetal abnormality in utero was not feasible. Recently the ability to detect certain fetal abnormalities has become available to the physician through the technics of amniocentesis and ultrasound.

The first successful amniotic fluid culture was reported in 1966 by Steel and Breg.[1] In 1967 Jacobson and Baxter[2] proposed the use of early midtrimester amniocentesis as a method of providing information to the patient and her physician concerning suspected pathologic fetal conditions.

At the present time prenatal diagnosis is being done at a number of medical centers. This paper reports the results of 100 amniocenteses performed in the Medical Genetics Clinic of the Department of Medical Genetics with the cooperation of the Department of Obstetrics and Gynecology at the Indiana University School of Medicine.

During the 2½-year period methodology was continually updated. Initially, ultrasound was not employed prior to amniocentesis but placental localization by ultrasound is currently routine. Similarly, laboratory methods have improved over the period and results once requiring weeks are now available in about 10 days. In the earlier patients of the series we were concerned about the possibility of maternal cell contamination and resultant misdiagnosis of the amniotic fluid culture. More recently it has become possible by suitable cytogenetic technics to compare presumed fetal and maternal cells for chromosome markers unique to each individual. Thus, the methodology detailed below represents current technics (1975).

Procedure

The majority of the patients were referred by their attending physician. All patients have an appointment for ultrasound for placental localization on the same day or one to two days prior to the amniocentesis.

Ultrasound is used for placental localization (Figure 1), in order to avoid inserting the needle through the placenta during the amniocentesis. This is particularly important in Rh-negative patients, where Rh isosensitization can occur if fetomaternal exchange takes place at the time of amniocentesis. The length of gestation can also be estimated by ultrasound and twin pregnancies can be diagnosed as early as 6-8 weeks.

An appointment is made for the patient as close to 12-14 weeks' gestation as possible. The patient and her husband are usually seen together before amniocentesis is performed. Information is gathered

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Dr. Khairi is a USPHS Postdoctoral Trainee, PHS T22 GM 00008.

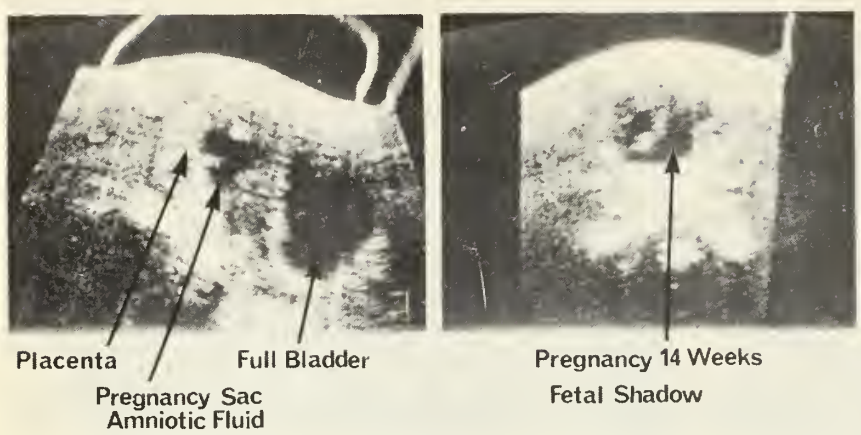


FIGURE 1

APPEARANCE of fetus and placenta at 14 weeks of pregnancy.

pertinent to the family history (i.e., previous congenital malformations, chromosomal anomalies, blood groups of both parents with special reference to the Rh factor). Rh-negative sensitive patients are told about the possibility of Rh isosensitization after a bloody tap. (Should this occur, Rhogam (Ortho Pharmaceuticals Corp.) is recommended.) An attempt is made to determine the attitude of the parents regarding the pregnancy, and towards termination of the pregnancy, if it is determined that the developing fetus is genetically abnormal.

The procedure is described along with possible hazards and limitations. An informed consent form explaining the complications is signed and witnessed (see Appendix).

At 14-16 weeks of gestation amniocentesis is a relatively safe procedure and 20-30 ml of amniotic fluid can be withdrawn easily. Attemps to do amniocentesis at earlier stages of pregnancy may result in a higher incidence of failed attempts. In our experience, the majority of the patients had amniocentesis performed between 15-16 weeks of gestation.

Assessment of duration of gestation is made by palpation of the height of the uterine fundus above the symphysis pubis. Assessment of the duration of gestation is important in some assays (i.e., alpha fetoprotein) where abnormal values are calculated in relation to gestational age of the fetus.

The site selected for amniocentesis is usually midline and suprapubic. The skin is prepared and, after inquiring about allergies, the skin and deeper fascia are infiltrated with local anesthesia using 1% Xylocaine. A 20-gauge spinal needle with a stylet is inserted midline about 3-4 cm suprapubic, the needle directed slightly cephalad. The first 5 cc of amniotic fluid is withdrawn and then the syringe is changed. The remaining 25-30 cc is drawn with successive 10 cc syringes. This step is included to avoid possible maternal cell contamination.

At this point the fluid is transmitted to the laboratory. Cells are centrifuged, the fluid decanted and the cells resuspended in tissue culture medium (F-10 + 20% fetal calf serum), aliquoted to T-30 plastic flasks, and incubated at 37C

TABLE 1

Indications for Amniocentesis

	Number of Patients in the Study
1. Chromosomal anomalies:	
a. Previous trisomic children	41
b. One parent a translocation carrier	4
c. Other chromosomal anomalies	2
2. Maternal age over 35	48
3. Neural tube defects	13*
4. X-linked disease	2
5. Possible irradiation damage	1
6. Metabolic diseases	1
TOTAL PATIENTS*	100

*Some had both alpha fetoprotein determination and chromosome analysis.

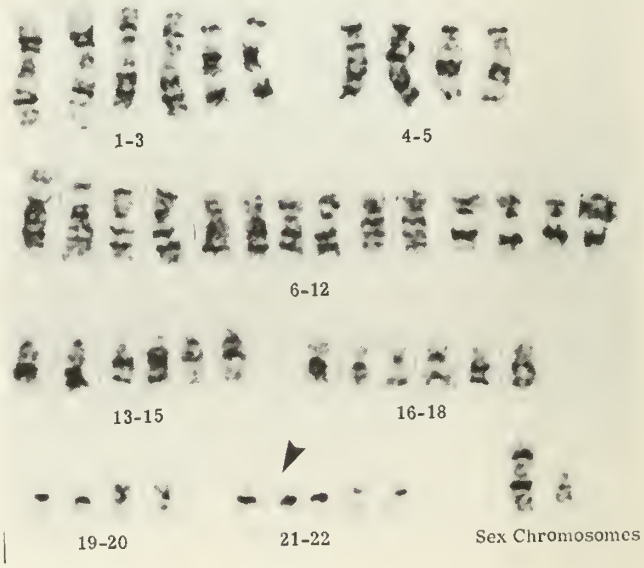


FIGURE 2

KARYOTYPE of fetus with trisomy 21 47(XY;+21) diagnosed by amniocentesis.

for 6-7 days before they are disturbed. Subsequently, the medium is changed every 3 days and the cells are ready to be fixed at day 10-14. The cells are treated with colcemide, fixed and standard air-dry preparations are made. The slides are either stained directly with Giemsa, trypsin banded, or stained with quinacrine mustard (QM) for fluorescence microscopy. A minimum of 2-3 trypsin-banded karyotypes and 30 cells per patient are examined for chromosomal abnormalities.

The possibility of maternal cell contamination has been a concern of investigators, especially in situations where a female karyotype has been found after amniocentesis. To avoid this possibility, maternal leukocytes are cultured and chromosomal variants unique to the mother are observed by staining with QM. These are compared with variants seen after similar staining of the fetal cells. There are seven pairs of chromosomes which may carry bright variants with QM staining. Since one member of each pair is contributed by the father, it is possible to recognize differences in fetal and maternal cells in as many as seven chromosomes.

At present, all alpha fetoprotein estimations are sent to another laboratory.*

It normally takes 10 to 14 days for final results on the chromosome analysis, and three weeks to obtain alpha fetoprotein results. It is urgent that the amniocentesis be done early so that results may be available before 20 weeks' gestation. Indiana state law does not permit termination of the pregnancy beyond 20 weeks of gestation. As soon as the results are available, the referring physician is contacted by phone.

Results

Indications for Amniocentesis

The reasons for referral of the patients seen in the clinic of the Department of Medical Genetics for diagnostic amniocentesis are shown in Table 1. The majority of patients are referred to this department to rule out Down's syndrome, either because of having previously delivered a child with Down's syndrome or because of increased maternal age.

There were 41 patients with previous children with Down's syndrome; 37 of these were young mothers (between 21-34 yrs.) and 4 were between 35 and 43 years of age. Forty-eight patients had amniocentesis to rule out Down's syndrome because of advanced maternal age which varied between 35-46 years. The incidence of Down's syndrome rises rapidly among children of mothers beyond age 35, the risks at respective ages being: 35-39, 1:300; 40-44, 1:100; 45 years and above, 1:40.[3] The majority of our patients had previous normal pregnancies, although three were pregnant for the first time. In total, there were 89 referrals to rule out Down's syndrome; among these we had only 1 case where cells from the amniotic fluid were chromosomally abnormal (one where a previous trisomy 21 child was born). We were, thereby, able to allay anxiety in 88 patients by confirming a normal karyotype.

Family No. 449: The mother was 21 years of age and had delivered a previous trisomy 21. This couple was first seen by the Department of Medical Genetics after the birth of the mongoloid child (confirmed by chromosome studies). They were counseled that their recurrence risk was about 1:500, as compared to 1:1500 in the general population for this age group.[3] Amniocentesis was suggested for future pregnancies. When the mother did become pregnant, chromosome studies on the amniotic fluid at 17 weeks' gestation showed that the fetus carried trisomy 21 (47,XY+21) (Figure 2). The parents chose to abort the fetus.

Three patients with a previous family history of translocation were studied.

Family No. 4280: There was a paternal family history of t(13q;14q) translocation. Amniocentesis was done at 18 weeks' gestation. Chromosomes of the fetus were shown to carry the translocation between the 2 D group chromosomes, the karyotype being 45,XY-13,-14,t(13q;14q). A fetus of this karyotype would be a carrier of the translocation and would not be expected to be clinically abnormal. The mother delivered a normal male infant.

Family No. 21454: There was a maternal family history of a translocation between the short arms of a D and G group chromosome t(DqGq). These families have a 10% risk of having a child with Down's syndrome.[4] Amniocentesis was done at the 18th week of pregnancy. Amniotic fluid obtained was clear. Chromosomes of the fetus were found to have a translocation involving two entirely different chromosomes, 7 and 18 (46,XX, t(7;18)(q32;p23) (Figure 3), and subsequently the father was found to be a carrier of the translocation.[5] The family chose to abort the fetus.

Family No. 2582: The patient was a carrier of translocation between 2 D group chromosomes t(13q;14q) and had one child with trisomy D syndrome with the t(13q;14q) translocation. Amniocentesis was done at 11 weeks of gestation. Chromosomes of the fetus were karyotyped as 46,XX. A normal female infant who weighed 6 lb. 12 oz. was delivered.

Family No. 21906: This 30-year-old mother was a translocation carrier t(14q;21q), with one previous carrier and one affected child. Amniocentesis was done at 18 weeks and the fetus was found to have normal 46,XX chromosomes.

Two patients were referred to our department because of chromosomal anomalies other than trisomy.

Family No. 1596: This 32-year-old mother had a previous child with cri-du-chat syndrome (46,XX, 5p-). Amniocentesis was performed at 15 weeks of gestation. Prenatal diagnosis showed the fetus to be 46,XY. A normal male infant was

*Dr. A. Milunsky, Kennedy-Shriver Institute, Boston, Mass.

delivered weighing 7 lbs. 9 oz.

Family No. 20391: Amniocentesis was done at 16 weeks' gestation on a 32-year-old mother of an earlier child with a deleted chromosome 5 (5p-). Prenatal diagnosis showed fetal chromosomes to be 46,XX.

In sex-linked recessive disorders, a male fetus would carry a 50% chance of being affected.

Family No. 477: This mother was a carrier of Pelizaeus-Merzbacher syndrome, an X-linked recessive disorder.[6] Amniocentesis was performed at 16 weeks. Chromosomes of the fetus were 46,XX and the mother delivered a 7 lb. 1 oz. female.

Family No. 21892: One patient was referred with a family history of muscular dystrophy. She had two affected male children previously. The patient was 38 years of age; therefore, there was concern about a possible mongoloid child. She was found to be carrying a 46,XX female fetus who might carry the gene for muscular dystrophy.

The association between high alpha fetoprotein levels in amniotic fluid and anencephaly has now been firmly established, and amniocentesis done between 14-20 weeks pregnancy for alpha fetoprotein estimation has become a routine screening procedure. The results are accurate in 95-98% of the cases. However, there is a small margin of error with this technic. In the skin covered myeloceles and spina bifida cystica, or in the rare cases of exencephaly auria and of iniencephaly, the results may be falsely negative. In high risk cases—i.e., where there is a strong family history of previous anencephalies or where one parent has had spina bifida, the indication for amniocentesis for alpha fetoprotein is strongly suggested. With this approach nearly all anencephalous and nine out of ten cases of serious neural tube malformations compatible with life should be detected. Alpha fetoprotein estimation was done in a number of cases because of a previous history of anencephalic pregnancies.

Family No. 20273: The patient, age 31, had previously given birth to a normal female infant. Her second marriage resulted in the following pregnancies: a 20-week gestation anencephalic fetus weighing 330 gm, and an anencephalic male fetus at 24 weeks' gestation. On the basis of previous obstetric history amniocentesis was performed at 17 weeks' gestation. Ultrasound at that time failed to show fetal skull. Amniotic tap revealed abnormal alpha fetoprotein levels and normal female chromosomes 46,XX differing in three chromosomal polymorphisms from maternal cells. A repeat ultrasound failed to show fetal head. On the basis of the above finding, pregnancy was terminated. A fetus with male external genitalia weighing 110 gms, with anencephaly and spina bifida up to the midthoracic region, was observed grossly. However, internal organs included ovaries and uterus (to be reported elsewhere).

Prenatal diagnosis of the neural tube defect reported above confirms the importance of clinical use of the alpha fetoprotein determination in pregnancies with a history of previous similar abnormality.

Family No. 21835: One patient was referred because of receiving, three years earlier, 3420 R to the abdomen during treatment of Hodgkin's disease. She had subsequently become pregnant and delivered a normal male infant who is now three years of age. Concern for irradiation-induced chromosomal abnormalities in the fetus led to chromosomal analysis. Chromosome studies did not reveal any chromosome damage and 46,XX normal chromosomes were present in the fetus.

One patient was referred to rule out an inherited metabolic defect in the fetus. In the majority of these cases, high risk pregnancies are only identified *after* the birth of a child with an inborn error of metabolism. When a family history is positive for a particular metabolic defect, it is possible to diagnose the disease in the fetus either from amniotic fluid or cells cultured from the fluid. Some diseases amenable to prenatal diagnosis are: cystinosis, Fabry disease, Sandhoff disease, galactosemia, Gaucher disease, Krabbe disease, Lesch-Nyhan syn-

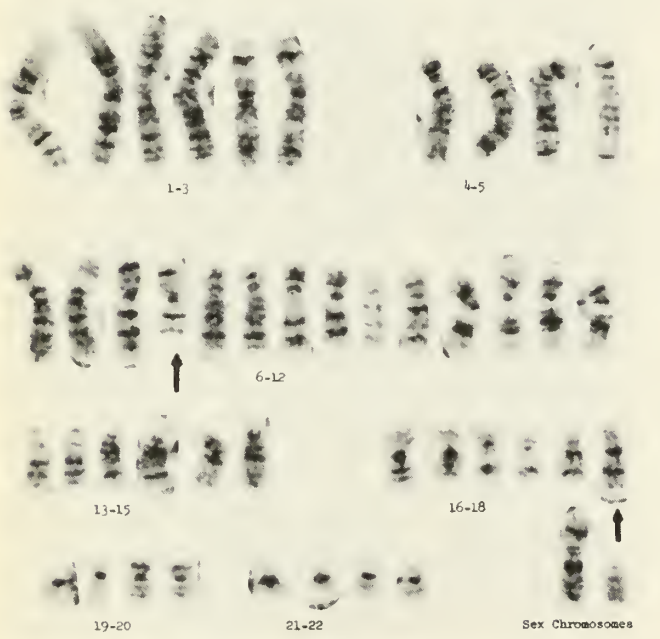


FIGURE 3

KARYOTYPE of fetus with translocation of chromosomes 7 and 18 (46,XY, t(7;18) (q32;p23).

drome, maple syrup disease, Niemann-Pick disease—type A, Tay-Sachs and the mucopolysaccharidoses.

Family No. 20105: This 22-year-old mother had a previous child with Sandhoff disease, a recessively inherited metabolic defect. Amniocentesis was done at 11 weeks' gestation and hexosaminidase A and B activity in the amniotic fluid was tested and was found to be within normal range with both synthetic and natural substrate. The fetus was determined to have 46,XX chromosomes. She subsequently delivered a normal female infant weighing 7 lbs. 12 oz.

Complications of Amniocentesis

The complications of amniocentesis found in our study in relation to those reported in the literature are summarized in Table 2. We found microscopic evidence of blood in amniotic fluid in 12 of the cases at the first attempt. It has been reported by Fuche[9] that a brown discoloration of the amniotic fluid implies that the fetus is dead at the time of sampling, whereas aspiration of greenish fluid may indicate perforation of the small bowel. We have, thus far, not encountered this.

One patient aborted two days after amniocentesis. To the present date we have had no case of infection following amniocentesis nor has any fetal injury been noticed at birth of the infants.

Chromosomal Differences in Maternal and Fetal Cells

Chromosomal polymorphisms are normal variants of human chromosomes which were studied in these cases by QM staining and fluorescence microscopy. The variants contributed by each parent can be recognized since they are transmitted from each parent to the child. Thus, the fetus can differ from the mother in a number of marker chromosomes of paternal origin.

We use these differences to distinguish fetal cells from maternal cells which might be accidentally transferred to culture at the time of amniocentesis.

All female fetuses which we have studied to date have differed from the mother in at least two chromosomes and in as many as six chromosomes (Table 3). Thus, it was possible by use of these chromosome markers to verify that the cells which were cultured were of fetal and not maternal origin.

Follow-up of the pregnancies for congenital malformations revealed one premature birth, one child with meningomyelocele which occurred prior to time when alpha fetoprotein determinations were available, one child with omphalocele and extrophy of the bladder, one child with malposition of great vessels, one infant with clubbed feet. The incidence of these abnormalities is within the limits found in the general population.[10]

A comparison of sex prediction by chromosome analysis and the sex at delivery shows that our sex determination was accurate in all cases (Table 4). The chromosomal sex determined prenatally was compared with information on the child's sex taken from the delivery records. No attempt was made to repeat chromosome studies on the newborn infant.

Discussion

The prevention of fetal abnormalities and malformations has been the hope of every obstetrician, pediatrician and geneticist. With midtrimester amniocentesis it has become possible to detect certain abnormalities early enough so that the patients may make decisions regarding selective abortion. We have found that an increasing number of patients of high risk pregnancies are choosing to have amniocentesis. The risk of abortion in performing amniocentesis should not exceed the risk of delivering a chromosomally abnormal infant. The risk of abortion after amniocentesis is about 1% in our experience and in other centers in-

TABLE 2

Possible Complications of Amniocentesis

	Number of Patients in the Study
1. Bloody taps	12
2. Abortion within one week of procedure	1
3. Vaginal hemorrhage and abdominal cramps	—
4. Failure to obtain fluid at first attempt	4
5. Failure to obtain fluid on second attempt	2
6. Failure to obtain fluid culture	1
7. Fetal injury	—
8. Infection, amnionitis	—
9. Maternal syncope	—

TABLE 3

Number of Chromosomes Differing in the Mother and Fetus

Number of Differing Chromosomes	Number of Mother/Fetus Pairs With Differences
2	4
3	4
6	1

TABLE 4

Comparison of Sex Prediction By Chromosome Analysis and Information as to the Sex at Delivery

	Results of Amniocentesis	
Sex	Chromosomal Sex	Sex at Delivery
Female	51	51
Male	49	49

volved with amniocentesis. The incidence of abnormal pregnancies in our study is not higher than that found in the general population.

We believe that the field of antenatal genetic diagnosis is a good example of the need for collaboration between referring physicians and a team trained to do prenatal diagnosis. Although we diagnosed few abnormalities in utero, we believe we were able to allay anxiety and apprehension of the pregnant women by determining normal karyotypes in the fetus in the majority of cases. If this procedure had not been available to the patients, they may have not attempted another pregnancy, or those who became pregnant might have spent the remaining seven to eight months of pregnancy in anxiety and fear of producing an abnormal child.

ACKNOWLEDGMENT

We wish to thank Lillian Wang for her excellent help in the laboratory and Dr. Ray Antley, both of whom were involved in the initial stages of these studies. We would also like to thank Dr. W. Ragan and Ms. Nancy Myers of the Department of Obstetrics and Gynecology for the ultrasound procedure on the patients. We appreciate the help of Dr. W. Zeman and V. Patel of the Department of Pathology in the prenatal diagnosis of Sandhoff disease.

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APPENDIX

Prenatal Amniocentesis
Indiana University Medical Center
Department of Medical Genetics

We, the undersigned, have requested that a prenatal evaluation of our unborn child be done. We understand that the materials required for such an analysis are obtained from amniotic fluid withdrawn during a trans-abdominal amniocentesis. This procedure involves the use of a local anesthetic and penetration of the patient's abdomen and uterus with a small bore hypodermic needle.

The following points have been specifically explained to us. We understand them and accept the risk associated with them:

1) A local anesthetic agent will be used. The physician has inquired about previous adverse reactions to this agent and similar type agents. We understand that even in the absence of previous adverse reactions, fainting and convulsions may rarely occur.
2) The insertion of a needle through the wall of the abdomen and uterus is usually free of complications for the mother. Sterile equipment and procedures are used to minimize the chance of infection at the site of the puncture, but occasionally such an infection can occur. Fainting may rarely occur during such a procedure.
3) Spontaneous abortion or premature labor may result following amniocentesis in one per cent (1%) of such procedures.
4) While it is possible to damage the fetus wtih the needle, it is unlikely that this would happen.
5) Attempts to obtain amniotic fluid may be unsuccessful and may have to be repeated at a later date.
6) Once the fluid has been obtained, the tests may not provide the needed information.
7) Every attempt will be made to arrive at an accurate diagnosis. However, as with all laboratory tests, there is a margin of error.
8) Some fetal anomalies cannot be detected by tests on amniotic fluid. Test results interpreted as normal do not rule out the possibility of undetected fetal anomalies.
9) If the patient and her husband choose to terminate the pregnancy after the test results are explained to them, the Indiana University Medical Center has the facilities and personnel to safely carry out the procedure.

In full understanding of the risks to the mother and fetus, we wish to have an amniocentesis for prenatal diagnosis attempted.

Signature of Patient

Signature of Spouse

Witness

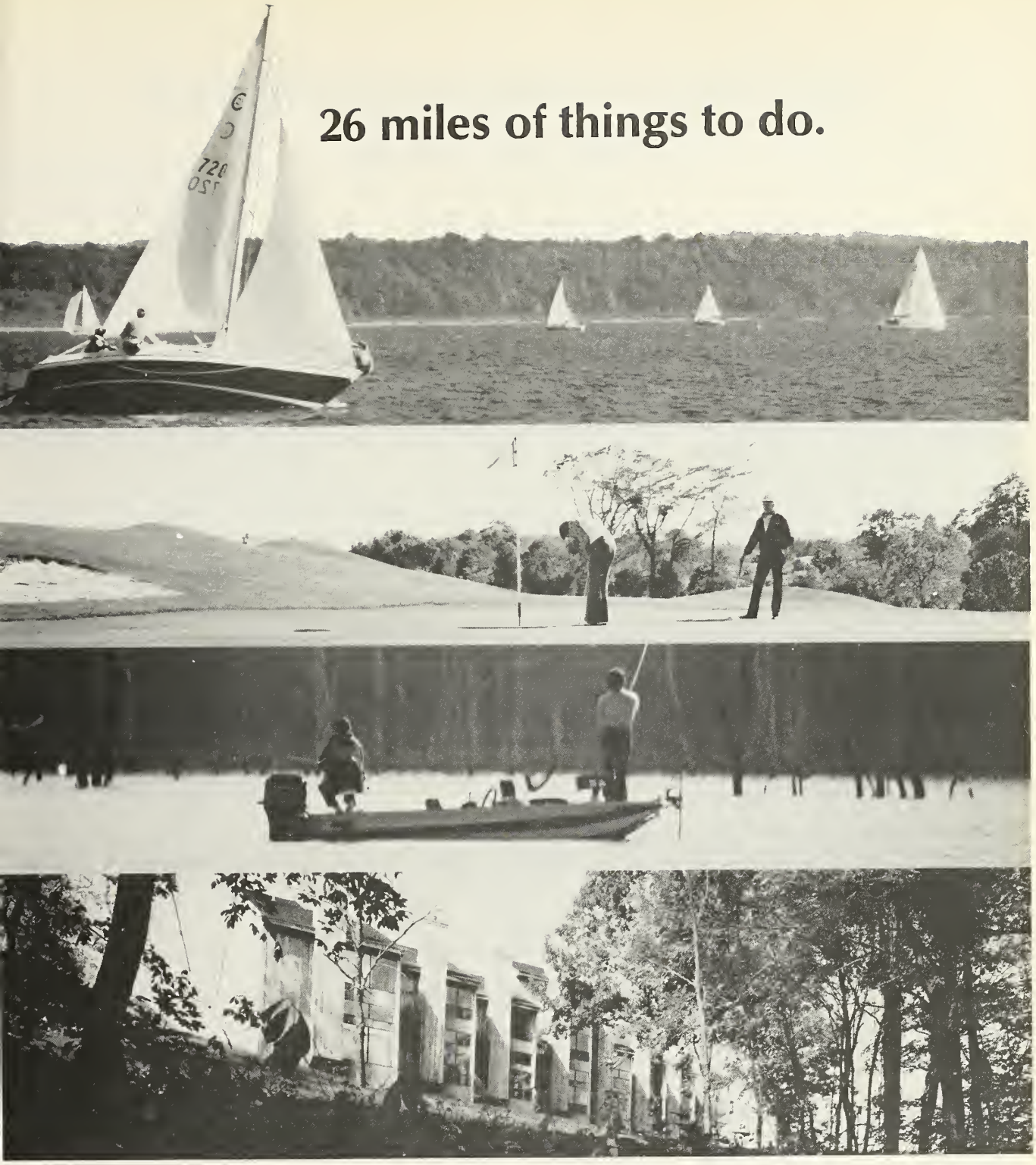
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Fatal Group B Streptococcal Septicemia in Newborn Twins

DAVID H. MOORE, M.D.
RICHARD L. SCHREINER, M.D.
Indianapolis

A recent increase in the incidence of neonatal infections due to Group B beta hemolytic streptococcus has occurred, with an attack rate up to 3.0/1000 live births.[1-4] Besides the serotype of the organism, neonatal Group B streptococcal infection is frequently classified according to the age of the patient—i.e., early onset if occurring at less than 10 days of age, and late onset if occurring after 10 days of age.[5] The purpose of this paper is to describe fatal Group B streptococcal septicemia in newborn twins and to review the literature concerning clinical signs, associated risk factors and epidemiology, with particular emphasis on the early onset type. Three previous occurrences of Group B infection in newborn twins have been documented.[6,7,9]

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Supported by National Foundation—March of Dimes Medical Service Grant No. C-117.

Case Report

A 19-year-old gravida 1 para 0 white female in labor was admitted to her local hospital during the 33rd week of pregnancy. The pregnancy had not been complicated by maternal infection and the mother had received no medication. There was no history of fever or vaginal discharge. Immediately following artificial rupture of the membranes two male infants were born in rapid succession.

Twin A, 970 gm, was delivered by vertex presentation with Apgar scores of 8 and 7 at one and five minutes respectively. Physical examination at birth and at 6 hours of age upon transfer to Indiana University Medical Center revealed a healthy appearing, small for gestational age, premature infant. Serum calcium, glucose, electrolytes, white blood cell count, hematocrit, and platelet count were all normal at 8 hours of age. Chest x-ray on admission revealed normal pulmonary vasculature and cardiac size, but mild streaky interstitial infiltrates compatible with either pneumonia or "transient tachypnea" were present. At 22 hours of age the infant became apneic. After blood and urine cultures were obtained, Ampicillin and Kanamycin were begun. At 31 hours of age intractable apnea necessitated ventilator support. Severe hypotension was treated with a 5% protein solution and blood transfusions. Persistent hypotension, metabolic acidosis, abdominal distention, fall-

TABLE 1
Clinical Data from Reported Series of Early Onset Group B Streptococcal Infection

	Franciosi[1]	Hey[8]	Baker[2]	Quirante[9]	Reid[3]	Horn[10]	Tseng[4]	Echeverria[7]	Vollman[12]
Number of cases	17	6	13	17	7	6	12	16	25
Mortality (%)	71	100	46	94	57	50	50	31	48
Symptoms									
Respiratory distress	100%	83%	100%		100%	100%	67%	100%	96%
Apnea	100%	17%		76%		17%			
Cyanosis	100%					17%	33%		
Seizures		17%		18%		17%	9%		
Lethargy		17%		6%		17%	17%		
Low birth weight (%)	ND	50	80	100	100	17	42	ND	ND
PROM (%)	ND	17	62	12	43	17	33	19	ND
Premature (<37 weeks) (%)	53	50	ND	77	86	ND	75	56	64% (<38)
Predominant serotype (%)	I-65	ND	III-56	ND	ND	II-50	ND	ND	ND

ND = No data
PROM = Prolonged Rupture of Membranes (>24 hours)

TABLE 2
Statistical Data from Reported Series of Early Onset Group B Streptococcal Infection

	Tseng[4]	Franciosi[1]	Baker[2]	Reid[3]	Bergquist[11]	Eidelman[17]
Vaginal colonization (during third trimester) per 1,000 pregnant women	ND	46	254	49	140	89
Neonatal colonization per 1,000 live births	ND	12	262	19	41	25.5
Neonatal septicemia per 1,000 live births	0.76	2	2.9	2.7	ND	2.2

ND = No data

ing hematocrit, gastrointestinal hemorrhage and thrombocytopenia failed to respond to vigorous supportive therapy including exchange transfusion, and the patient died at 48 hours of age. Blood and urine cultures grew Group B streptococcus, serotype Ic.* Autopsy revealed multiple sites of hemorrhage, including the peritoneum, brain, liver, esophagus, stomach and duodenum, and adrenal cortical atrophy, renal tubular necrosis and bilateral pulmonary atelectasis.

Twin B, 1260 gm, was born by breech presentation and had Apgar scores of 6 and 7 at one and five minutes respectively. Physical examination at birth was unremarkable but at 3 hours of age mild respiratory distress with associated hypothermia developed. At 8 hours of age serum calcium and electrolytes, complete blood count and differential, and platelet count were all within normal limits. A chest x-ray revealed normal heart size and pulmonary vasculature but streaky interstitial infiltrates consistent with either pneumonia or "transient tachypnea" were noted. Blood and urine cultures were obtained. Apnea and respiratory distress recurred at 10 hours. Ampicillin and Kanamycin were then begun. Intractable apnea and cyanosis necessitated ventilator support. Gastrointestinal hemorrhage, metabolic acidosis, hypoxia and hypotension persisted despite vigorous supportive therapy and death occurred at 36 hours of age. Blood and urine cultures subsequently grew Group B streptococcus, serotype Ic. Postmortem examination revealed intraventricular, superficial gastric and superficial esophageal hemorrhages. Bilateral atelectasis, hepatomegaly, ascites, adrenal cortical atrophy, and renal tubular necrosis were also noted.

A culture obtained from the maternal vagina 5 days postpartum grew *Escherichia coli* as the predominant organism and *staphylococcus epidermidis.*

*Serotyping courtesy of: Richard R. Facklam, Ph.D., Chief Staphylococcus and Streptococcus Unit, Clinical Bacteriology Section, Center for Disease Control, Atlanta, Ga.

Discussion

The non-specific symptomatology and high mortality rate associated with early onset Group B streptococcal septicemia present a diagnostic and therapeutic challenge. While respiratory distress is the most common clinical presentation (Table 1), apnea, cyanosis, fever, hypotension, lethargy and hypothermia are also early warning signs. Radiographic findings are non-specific.[1,7,12] Prolonged and difficult labor and delivery, prematurity, low birth weight, low Apgar score and evidence of maternal infection (perinatal fever, vaginal discharge, prolonged ruptured membranes) may represent further causes for diagnostic alertness.

The cases presented in this paper illustrate the difficulties associated with early diagnosis and management of early onset Group B septicemia. There were no complications of labor and delivery or evidence of maternal infection. Mild respiratory distress and apnea were the only early signs. The hospital course was precipitously downhill despite aggressive management.

The route of infection in early onset Group B septicemia is currently accepted as maternal-to-fetal transmission at or immediately prior to delivery.[1,2,11] This contrasts with late onset septicemia and/or meningitis, in which both nosocomial reservoirs as well as maternal-to-fetal transmission have been implicated.[1,5,13,14] An increased incidence of asymptomatic vaginal colonization in pregnant women at term parallels the rising incidence of neonatal Group B infection.[15]

Marked variation in vaginal colonization rates and neonatal infection rates (Table 2), lack of large prospective studies and evidence of male infection reservoirs[1] make decisions relative to prophylactic treatment of pregnant vaginal carriers and their infants difficult. Recent retrospective data implying that the routine prophylactic administration of penicillin G at the time of birth may be associated with, and perhaps responsible for, an extremely low incidence of early onset septicemia warrant further investigation.[16] Confusion will persist however, until well-controlled, double-blind, prospective studies are available. A high index of suspicion, based on predisposing factors and nonspecific clinical and radiologic data, coupled with aggressive management must be exercised. ◄

(A copy of the references pertaining to this paper may be obtained by writing *The Journal* office.)

CANCER CORNER

New information from
Indiana Division
American Cancer Society, Inc.
2702 East 55th Place
Indianapolis 46220

Primary Care Physician Clinical Update

Recent Clinical Advances
in the Management of the
Patient with Malignant Disease
Friday, Nov. 5, 1976
Stouffer's Inn, Indianapolis

The purpose of this conference is to inform the *PRIMARY CARE PHYSICIAN* of the newer clinical developments in medical oncology.

Speakers include nationally recognized authorities such as: Joseph Burchenal, M.D. (Memorial-Sloan Kettering); Clara Bloomfield, M.D. (University of Minnesota); Robert Young, M.D. (National Cancer Institute); Douglas Tormey, M.D. (University of Wisconsin), and Richard Bakemeier, M.D. (University of Rochester), who will join with Lawrence Einhorn, M.D. (Indiana University) to discuss recent advances in breast, ovarian and testicular cancer, acute leukemia and the exciting trends in adjuvant chemotherapy and immunotherapy.

The conference is co-sponsored by ADRIA LABS and Indiana Division, American Cancer Society.

For further information: Division of Postgraduate Education, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46202.

* * *

Every Physician's Office—A Cancer Detection Center

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Editor's Ashtray

(Partial reprint of article in *Cancer News,* Vol. 30, No. 2, Spring 1976, published by the American Cancer Society, Inc.) New information on smoking among teen-age girls and young women:

A new ACS sponsored study of cigarette smoking among teen-age girls (13-17) and young women (18-35) points up four major trends: 1) a dramatic increase in cigarette smoking by teen-age girls and an increase of really heavy smokers (more than a pack a day) among young women; 2) Great awareness of the anti-smoking message; but 3) An all-pervasive smoking environment, which overwhelms what these two groups have seen, heard or read about the dangers of smoking, and 4) Changing youth values—which emphasize the emotional over the rational, making it easier to resist arguments against smoking.

The study points out that, ironically, the barring of cigarette commercials from TV and radio and the resulting sharp reduction in free air time for anti-smoking messages meant a drastic cut in the "most dominant countervailing force" operating against the smoking environment.

Some other highlights of the study:

—Cigarette smoking among teen-age girls seems to be strongly correlated with rebelliousness.

—An interesting sub-group—christened the "Vulnerables" by the authors of the study—of teen-age girls, does not smoke but shares many of the same values as the smokers. While the Vulnerables seem to be prime candidates to become smokers, in reality they have somehow found some strong barriers to smoking: emphasis on physical fitness, concern about smoking addiction, and a militant anti-smoking attitude

—The teen-age girl smoker is apt to be a "C" or "D" student, the non-smoker an "A" or "B" student.

—Housewives are more likely to be heavy smokers than are working women.

Doctors quitting, more nurses smoking: According to the Anti-smoking Activities Report by ACS Divisions, only about one-fourth of doctors and one-fourth of dentists in their areas smoke—a level considerably below that of the general population. But two-fifths of the nurses smoke—a level higher than that of smoking in the adult female population.

Cigarettes and life-expectancy: A pack-a-day male cigarette smoker at age 45 can expect to live 5 to 6 years less than non-smokers of the same age. An ACS report points out that this means "the average cigarette smoker loses more life at that age than the average gain in life for the entire male population at age 45 which is associated with antibiotics, achievements in surgery, all other advances in medical science and practice and generally improved standards of living."

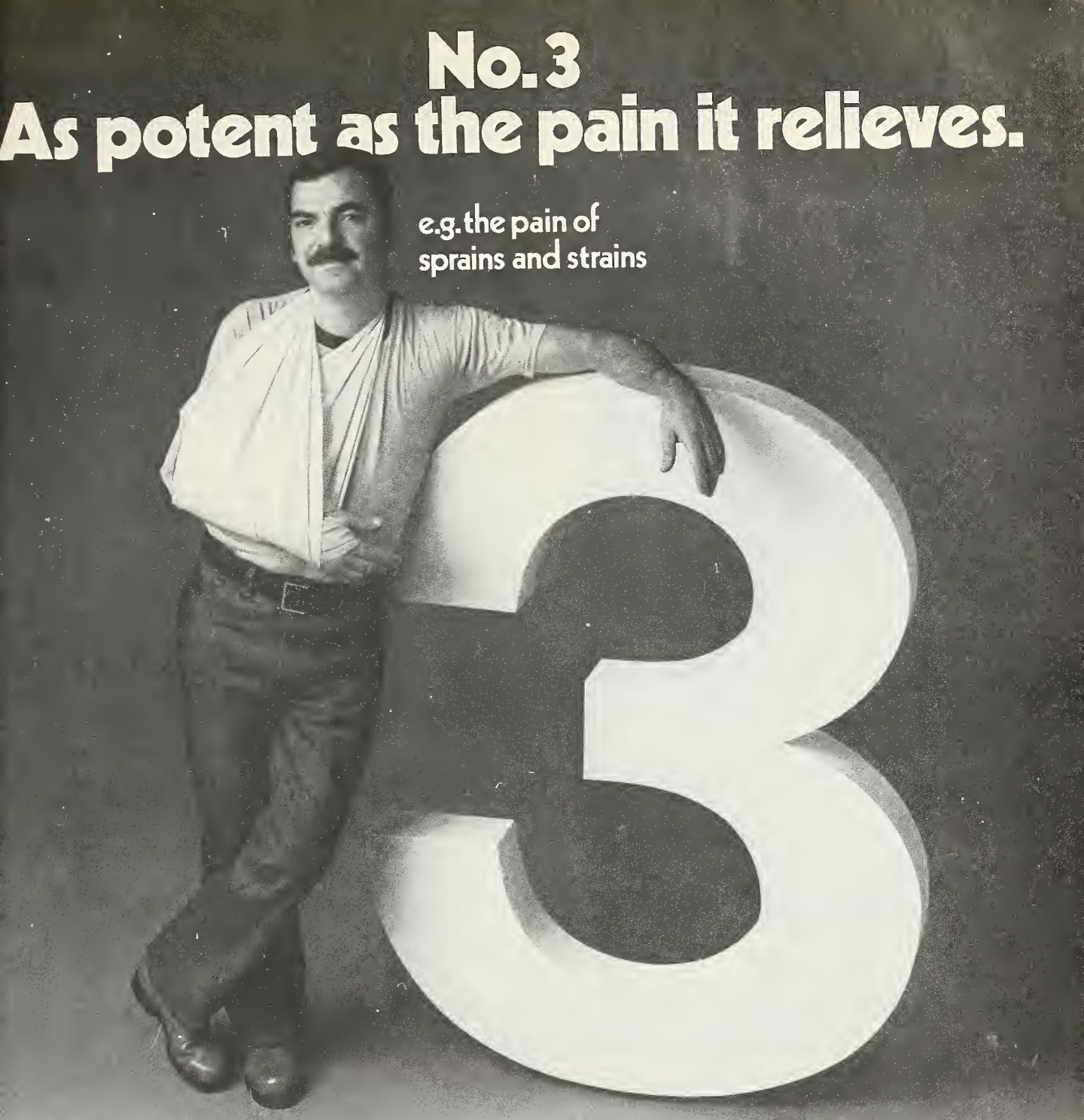
Costly smokers: A California study estimates that each smoking employee cost an employer $700 a year. The study considered such costs as smoking-related deaths, wages lost to smoking-related disability per year, non-executive employee man-hours lost per year, replacement costs of an executive, late discovery of smoking-related disease in employees, increased costs of health benefits and fire insurance.

Ex-cigarette smokers inhale cigars: In an effort to kick the cigarette habit, some people take to cigars. But they have become so used to inhaling that they inhale cigar smoke which might be even more dangerous, says Dr. Allen Goldman, a University of South Florida chest physician. In a report in the *Journal of the American Medical Association,* Dr. Goldman found that ex-cigarette smokers who now smoke cigars have about as much carbon monoxide in their blood as cigarette smokers, and four times as much as non-smokers.

WILLIAM M. DUGAN, JR., M.D.,
Vice President, Indiana Division
American Cancer Society, Inc.

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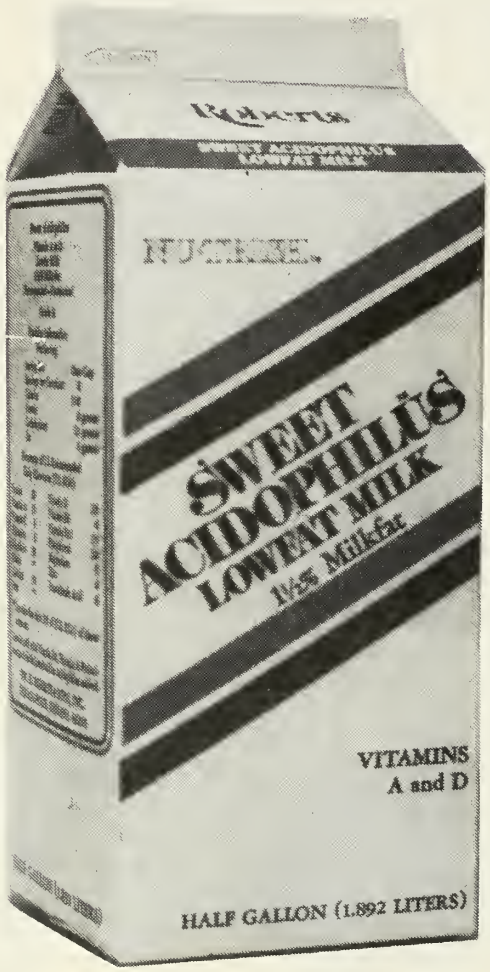
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Air Bags Safe and Efficient

SAFETY automatic air bags have been around long enough now to create considerable opposition from the auto industry. At the same time, fortunately, the air bags have made an almost unbelievable record of safety and efficiency.

Cars with air bags have logged over 250 million miles and have suffered 103 crash deployments over the seat bags. There were 129 front seat occupants involved and of these 125 survived.

Two of the fatalities occurred in a crash which demolished the car to such an extent that no safety devices could have possibly saved lives. One fatality was that of an infant who was unrestrained and whose head struck the instrument panel when he slid off the seat during pre-impact braking. The other fatality occurred in connection with a 30 MPH frontal collision with a utility pole. It is not known whether the driver died before, during or after the crash.

It is estimated from this record that universal use of air bags would save 8,800 lives annually and avoid or reduce injuries in many more cases.

The Insurance Institute for Highway Safety has produced a film report "Crashes That Need Not Kill" to recount the personal stories of drivers whose lives have undoubtedly been saved by the air bag. Many tell of frontal impacts with a combined speed of both vehicles of 50 to 60 MPH, in which the air bag functioned with inflation and deflation taking place before the driver realized what had happened.

The air bag will add to the cost of the car. It is estimated that front seat air bags and belts will increase the price of the car, over that of one equipped with belts only, by $103.

The air bag must be carefully serviced and adjusted, in order to be reliable. Already some test cars have carried bags which were not adjusted properly by service mechanics. Such bags have deployed without an accident. The drivers have all been surprised but none has lost control of the car as a result of the premature bag inflation.

Seat belts and shoulder straps are indicated in addition to air bags, since the bags protect only for frontal crashes.

All these things add up to a small price when compared to the injuries and deaths which may be prevented.

Guest Editorial

Before It Is Too Late

IT is apparent that at least some of the provisions of the legislation recently enacted in many jurisdictions and intended to resolve the malpractice problems are going to fall short of providing significant relief. As noted in this issue of the Journal, certain key provisions in one such statute have been held unconstitutional. Even if a statute withstands constitutional scrutiny, it will take years before any beneficial effects of tort reform, arbitration and limitation on damages are reflected in leveling or lowering of insurance premiums. Meanwhile, insurance available through joint underwriting authorities or similar plans cannot realistically be expected to be limited in cost.

What should the professional do if his liability insurance consumes too large a proportion of his income? Fees for professional services cannot be expected to be elevated further to encompass an ever-enlarging insurance overhead. Many physicians are "going bare," *i.e.*, practicing without any insurance. This "solution" undoubtedly eliminates the "nuisance claim." But it raises a host of other problems—sequestering assets, gift taxation—and bankruptcy, to name a few.

Early or temporary retirement from practice may resolve the problem for a few individuals. In the long run, however, it will only hamper the continuing delivery of a high quality of health care to the citizens of these United States. Nor would a federally funded system be the answer, even if it would preserve the present modality of reparations.

It seems to the editor that all

health care providers must now recognize that we may have to substitute a new reparations system for the present tort forum. It could take the form of compulsory medical injury insurance, a patient compensation commission or other plan.

One of the major objections to such a proposal is the argument that it would be too costly. In rebuttal, it can be stated that such a system would conserve the insurance assets and make available to the patient a far greater percentage of the premium dollar than at present. Such a proposal would also reduce injuries by the necessary imposition on hospitals and individual practitioners of medical injury prevention and loss control programs.

Reportedly a study is now under way in a large western jurisdiction to determine the projected costs of a reparations system based on iatrogenic complications rather than fault. This step is long overdue.

Any such solutions require legislative enactment and possibly state constitutional amendment as well. Legislators' response to lobbying and special interest groups for a proposal of this type is balanced by equal or greater pressures from those of opposite views—those who would preserve the present system. If meaningful legislation is to be enacted, the impetus for reform can only come from *constituents*—patients, health care providers acting *individually* and other parties.

All health care providers must work diligently toward the education of the public. It seems the system must be changed. The task will not be easy or quickly accomplished, but we must begin now before the cost of insurance makes the cost of health care prohibitive—before it is too late. **W.H.L.D.—*The Journal of Legal Medicine*, June 1976, William H.L. Dornette, M.D., J.D., editor. Reprinted with permission.**



"I THINK WE HAD BETTER EASE UP ON THOSE HORMONE SHOTS FOR A WHILE, MRS. VAN FEWTER."

Editorial Notes . . .

The American College of Surgeons and the American Board of Surgery will correlate the College's Surgical Education and Self-Assessment Program (SESAP) with the Board's recertification process. The first voluntary recertification examination will be offered in 1980. The Board will notify its candidates for recertification that they should be familiar with the body of knowledge covered by SESAP.

The reported rise in medical care costs for an "intermediate family," according to the Bureau of Labor Statistics, amounted to 45.7% between 1970 and 1975. This sounds like a lot but actually the percentage of after-tax income spent on medical care in 1970 was 6.5% and in 1975 it was 6.6%, really not a large increase. Again, according to BLS, family income before taxes went up by 43.6%, income after taxes went up by 42.1% —Food increased by 56.1%, medical care by the above-mentioned 45.7%, and social security taxes were up by 115.5%. More people should complain about high taxes rather than higher medical costs which really keep pace with income.

The scheduling of a conference on "The Rights of Children as Research Subjects" brings to mind the deplorable lack of clinical research of new drugs in children. Clinical research of new drugs is also delayed and even entirely lacking in pregnancy. It is easy to understand the desire to avoid injury to such research subjects but, on the other hand, new drugs are sometimes indicated and desperately so in children and in pregnant women. It would seem that, after a drug has been proven effective and safe for the ordinary adult population, the risk of testing it further would be minimal.

Upjohn research on prostaglandins indicates that some of the effectiveness of steroid agents in relieving inflammatory diseases may result from their preventing release of abnormally large amounts of prostaglandins. Nonsteroid agents such as aspirin and indomethacin also suppress prostaglandins.

The American College of Sports Medicine is calling attention to a medically unsound practice which is fairly common and may produce undesired clinical consequences. Has to do with wrestlers who compete in body weight classes and often have a difficult time making the weight. With only a few days in which to lose the excess, food deprivation, water restriction, artificial sweating, catharsis and diuresis are utilized. Repeated bouts of weight-losing immediately before competition undoubtedly place undue stress on cardiovascular and urinary systems. The College recommends a set of rules to eliminate the practice.

The recovery of silver from x-ray film and from x-ray developing solution is important for two reasons. One is that the world is now using silver faster than it is being mined—at this rate there will come a time when captive silver will be scarce and photography, including x-ray films, will also be scarce. Another reason is financial. Silver is worth more than $4 per troy ounce. In just one hospital system, the Veterans Administration, 235,397 troy ounces of silver was recovered from developing solution last year. Scrap x-ray film brought the VA $1,177,119. ◄

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* **Indications:** *Edema:* That associated with congestive heart failure, cirrhosis of the liver, the nephrotic syndrome; steroid-induced and idiopathic edema; edema resistant to other diuretic therapy. *Mild to moderate hypertension:* Usefulness of the triamterene component is limited to its potassium-sparing effect.

Contraindications: Pre-existing elevated serum potassium. Hypersensitivity to either component. Continued use in progressive renal or hepatic dysfunction or developing hyperkalemia.

Warnings: Do not use dietary potassium supplements or potassium salts unless hypokalemia develops or dietary potassium intake is markedly impaired. Enteric-coated potassium salts may cause small bowel stenosis with or without ulceration. Hyperkalemia (>5.4 mEq/L) has been reported in 4% of patients under 60 years, in 12% of patients over 60 years, and in less than 8% of patients overall. Rarely, cases have been associated with cardiac irregularities. Accordingly, **check serum potassium during therapy, particularly in patients with suspected or confirmed renal insufficiency (e.g., elderly or diabetics). If hyperkalemia develops, substitute a thiazide alone. If spironolactone is used concomitantly with 'Dyazide', check serum potassium frequently**—both can cause potassium retention and sometimes hyperkalemia. Two deaths have been reported in patients on such combined therapy (in one, recommended dosage was exceeded; in the other, serum electrolytes were not properly monitored). Observe patients on 'Dyazide' regularly for possible blood dyscrasias, liver damage or other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium (triamterene, SK&F). Rarely, leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with the thiazides. Watch for signs of impending coma in acutely ill cirrhotics. Thiazides are reported to cross the placental barrier and appear in breast milk. This may result in fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and possibly other adverse reactions that have occurred in the adult. When used during pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus.

Precautions: Do periodic serum electrolyte and BUN determinations. Do periodic hematologic studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in postsympathectomy patients. The following may occur: hyperuricemia and gout, reversible nitrogen retention, decreasing alkali reserve with possible metabolic acidosis, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), digitalis intoxication (in hypokalemia). Use cautiously in surgical patients. Concomitant use with antihypertensive agents may result in an additive hypotensive effect. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis; rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting (may indicate electrolyte imbalance), diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

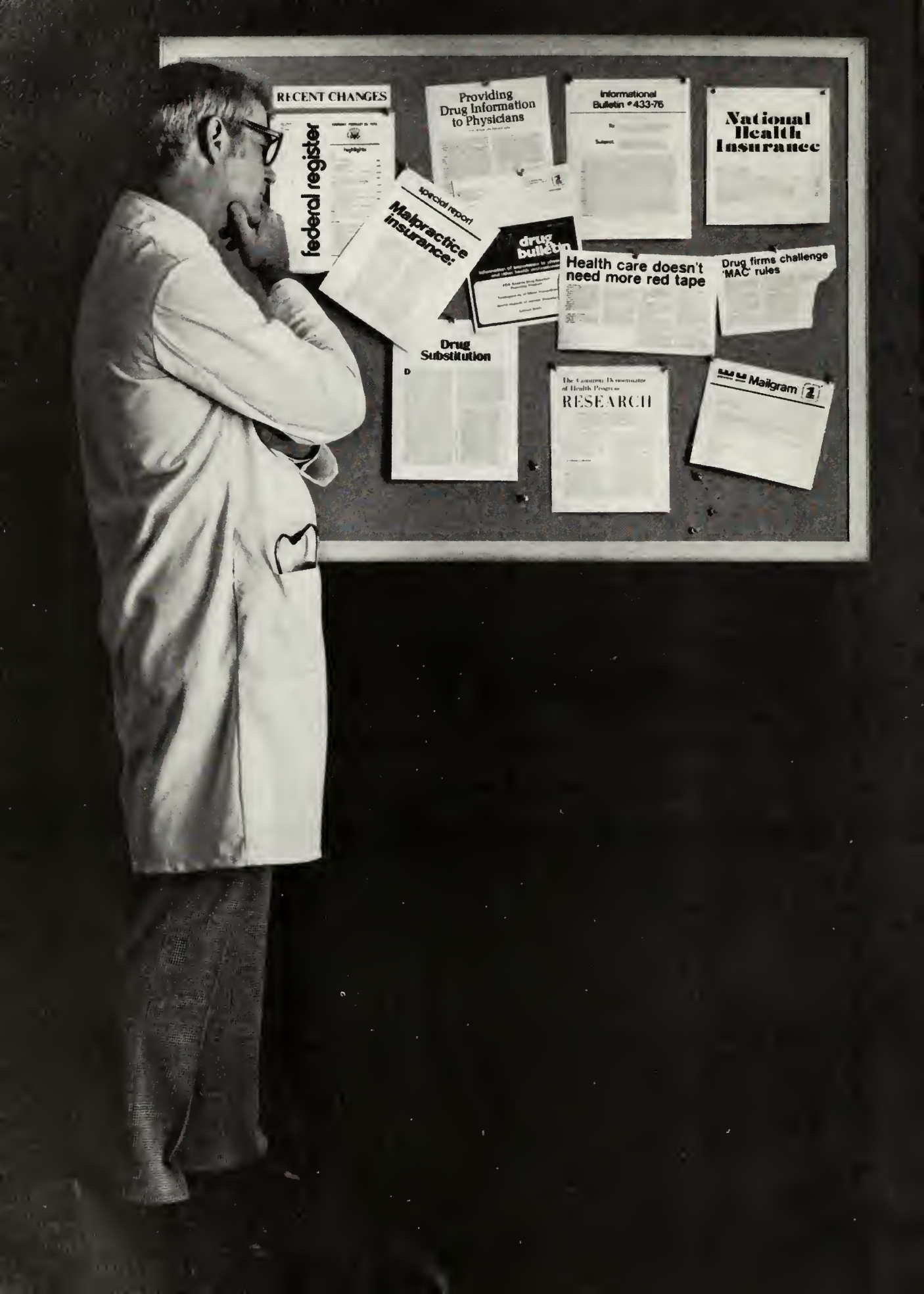
Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

MEDICAL MUSEUM NOTES





MEMBERS of the Class of 1926 outside the Old Pathology Building. Left to right are Drs. Arnold H. Barr, James B. Burcham, Nolan Montgomery, Morris B. Paynter, James V. Richart, Carl M. Davis, and Harold Halleck.

Wednesday, May 19, was Alumni Day at Indiana University School of Medicine. It was the occasion of the 50th anniversary of the Class of 1926. Among other things, the alumni had opportunity to visit the Old Pathology Building and to see how it is being developed into the Indiana Medical History Museum. Eli Lilly and Company provided bus service to transport interested visitors from the campus to the Museum. The Museum is located on the grounds of Central State Hospital, about a 10-minute ride from the campus. The accompanying photographs were taken on that occasion.



A group in the amphitheater listens intently to the history of Indiana University School of Medicine.



DR. SIMON GOLD, Class of 1936, views brain displayed in cabinet in the Pathology Section.



PAUSING for a chat in the Pathology Section are (left to right) Mrs. Arnold Barr, Dr. Carl M. Davis (Class of '26), Valparaiso, and Mrs. Davis.

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ISMA Commission Seeks Changes in Constitution

THE Commission on Constitution and Bylaws of the Indiana State Medical Association will present to the House of Delegates of the Association, in October 1976, the following revised Constitution.

For your additional information, the Commission in its study and revisions has discovered duplication of material in the Constitution and Bylaws. This new approach streamlines the Constitution, eliminates the duplications and incorporates other material currently contained in the Constitution into the Bylaws and simplifies understanding and readability of the document.

Changes in Bylaws will be presented to the House of Delegates at the first meeting of the House in October.

The following is the excerpt from the current Constitution explaining the process of revision:

ARTICLE XIV—AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates present at any Annual Convention, provided that such amendment shall have been presented in open meeting at the previous Annual Convention, and that it shall have been published twice during the year in *The Journal* of this Association.

Constitution

ARTICLE I—TITLE AND DEFINITION

The name of this organization is the Indiana State Medical Association. It is the federacy of Indiana county medical societies.

ARTICLE II—PURPOSES

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the state of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly relations among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care and public health so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies are those county and district medical societies contained within the state of Indiana, and who hold charters from this Association.

ARTICLE IV—MEMBERS

The Indiana State Medical Association is composed of individual members of county medical societies and others as shall be provided in the Bylaws.

ARTICLE V—HOUSE OF DELEGATES

The legislative and policy-making body of the Association is the House of Delegates composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in the Constitution and Bylaws and shall elect the general officers, except trustees, as otherwise provided in the Bylaws.

ARTICLE VI—OFFICERS

The general officers of the Association shall be a president, president-elect, immediate past president, executive director, treasurer, assistant treasurer, speaker, vice speaker, and the trustees. Their qualifications and terms of office shall be provided in the Bylaws.

ARTICLE VII—TRUSTEES

The Board of Trustees is composed of trustees and alternate trustees elected by the component district medical societies, and the president, the president-elect, treasurer, immediate past president, the assistant treasurer, with power to vote only in the absence of the treasurer, and the speaker and vice speaker without power to vote and the executive director without power to vote. The alternate trustees have power to vote only in the absence of the trustee.

ARTICLE VIII—THE CONVENTION

The House of Delegates and the general scientific program shall be convened annually and

at such other times as deemed necessary or as provided in the Bylaws, in cities recommended by the Board of Trustees and approved by the House of Delegates.

ARTICLE IX—FUNDS, DUES AND ASSESSMENTS

Funds may be raised by annual dues or by assessment of the active members on recommendation of the Board of Trustees or any other manner approved by the House of Delegates. Any change in dues or any assessment must be approved by the House of Delegates.

ARTICLE X—AMENDMENTS

The House of Delegates may amend this Constitution at any convention provided the proposed amendment shall have been introduced at the preceding annual convention and provided two-thirds of the voting members of the House of Delegates vote approval and provided that it shall have been published twice during the year in *The Journal* of the Association.

News from CHAMPUS

Erratum: It was stated in an article under this heading in the August issue (p. 599) that "Beneficiaries may file their own claim in which the amount is substantiated by an itemized statement of fees and supported by evidence of payment." It is not necessary that the claim be supported by evidence of payment. The itemized statement of fees is sufficient.

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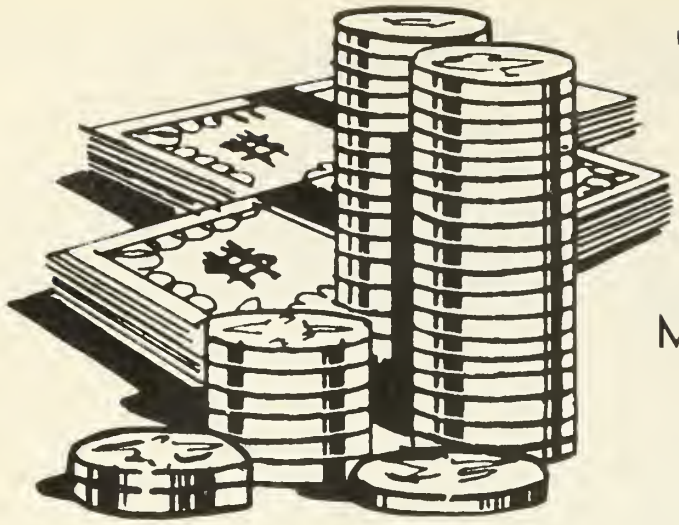
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INDIANA UNIVERSITY SCHOOL OF DENTISTRY
PRESENTS

PROFESSIONAL CORPORATIONS

MONEY MANAGEMENT

October 23 and 24, 1976

HARVEY SARNER, B.S., LL.B.

Airport Hilton Inn
Indianapolis, Indiana

INSTRUCTOR

Mr. Sarner holds B.S. and LL.B. degrees from the University of Minnesota. He is an attorney in private practice in Chicago, Illinois and President, Sarner and Associates. Mr. Sarner serves as an Instructor in Dental Jurisprudence at Indiana University School of Dentistry. Publications include the books "Dental Jurisprudence and the Business Management of Dental Practice," "Law for the Nurse," published by the W. B. Saunders Co. and "Insurance for the Doctor." He is author of various articles in dental and legal journals. Mr. Sarner was an attorney on the staff of the American Dental Association from 1961 to 1971.

COURSE SYNOPSIS

All 50 states have now enacted professional corporation laws. These new laws may frequently offer the possibility of substantial tax savings as well as other benefits. However, they may create some problems, and the doctor should be aware of these problems as he considers the question of incorporation.

By reputation doctors are adept at earning a reasonable income from their practice but poor at money management. Mr. Sarner will present realistic suggestions for getting the most out of your insurance and investments and for incurring the least possible Federal tax obligation. He is experienced in communicating complex financial ideas to professional people in a way that they can understand and apply.

In this two-day course, Mr. Sarner will explore the complexities of the professional corporation and efficient money management.

The topics to be discussed will include:

1. Purpose of professional corporations.
2. Potential advantages of a professional corporation.
3. The problems of incorporation.
4. State professional corporation laws.
5. Insurance and investing mechanisms for funding corporate pension and profit-sharing plans.

FEE. $100 doctor
$ 35 — auxiliaries or wives
(luncheons included)

For further information please write to Dr. Robert H. Derry, Director of Continuing Education, Indiana University School of Dentistry, 1121 West Michigan Street, Indianapolis, Indiana 46202.

Professional Corporations / Money Management

APPLICATION

I understand the fee for this course is $100, which accompanies this application. _____

I was graduated from _____ Year _____

Name _____ Date of Application _____

Address _____
Street and Number City State Zip Code

October 23 and 24, 1976

Please make check payable to Indiana University School of Dentistry and forward it with this application to Dr. Robert H. Derry, Director of Continuing Education, Indiana University School of Dentistry, 1121 West Michigan Street, Indianapolis, Indiana 46202.



BOOK REVIEWS

THE NEW WAY TO LIVE WITH DIABETES

Brian Boylon, M.D., Charles Weller, M.D., Doubleday-Dolphin Co., New York; 1976; $2.50.

I have reviewed this revised and updated publication and was impressed by the completeness of the information offered, the concise method of presentation and the new thoughts and changing procedures which are essential in diagnosing, evaluating and proper treatment of this very prevalent pathological state. The clear, simple and thorough coverage of the subject in this book is the best I have ever read.

I have had 40 years of active practice in Internal Medicine with special attention in the treatment of diabetes and have attempted, on occasion, to prepare a brochure for the benefit of patients, but I was never successful in producing a document as good as "The New Way To Live With Diabetes." Although the book is directed to the diabetic and the associated family, it is definitely an excellent review of the subject and should be available, for reference, by all practitioners.

In reviewing the book, I especially enjoyed the history, the new approach to the evaluation of diabetes, the recently changed concept of the use of oral hypoglycemic drugs and the comments as to the continuing research and the future programs stressing the increased education and psychological improvement of the diabetic patient.

I was privileged to conduct some of the clinical studies of the various oral hypoglycemic agents and, as I had expressed in two past meetings of the Indiana State Medical Association, when I discussed the use of the oral preparations, that their future use as a controlling medication was going to fail. The authors of the book are in accord with this opinion.

The chapters on the care, treatment, complications and a deeper insight as to just what the diabetic should do are certainly well written and should be a part of all diabetics' training.

For the sake of the seven-plus million known diabetics and the undiagnosed living diabetics and those who will develop this metabolic dysfunction in the future there is more hope for an eventual cure and, in the meantime, live the "New Way."

IRVIN W. WILKENS, M.D.
Indianapolis

What's New in Books?

A 16-page booklet "Coronary Heart Disease: Risk Factors and the Diet Debate" has been published by the National Dairy Council. It is intended for lay individuals in adult education, high school and college health classes, medical offices, etc. Written by Laurence Hursh, M.D., of the University of Illinois. Available at 40 cents per copy with discount for quantities. Write the Council at 6300 N. River Road, Rosemont, Ill. 60302.

* * *

Dell Distributing announces the release of book with articles by more than 20 philosophers, physicians and psychologists on how to reduce stress and overcome tension. It is edited by John White and James Fadiman and includes such contributors as Hans Selye, Aldous Huxley and Swami Karmananda. Paper back, $1.95.

* * *

Mosby announces a new book—Lois DeBakey, author—"The Scientific Journal: Editorial Policies and Practices—Guidelines for Editors, Reviewers, and Authors." The book is short on didactic statements and hard and fast rules—long on guidelines and flexible advice. 140 pages, $9.95.

* * *

Doubleday and Company announces release of a new book entitled "Hysterectomy." The author is Nancy Nugent, a prominent medical reporter. The book is a consumer's guide to medical care that explains to patients in everyday terminology exactly what they may expect and how this operation can change and often save their lives. 192 pages—$6.95.

* * *

Plenum has published "Genetics and the Law," a book which recognizes and probes all the major issues in human genetics which now confront the law. More than 40 internationally renowned scientists, physicians, lawyers and ethicists explore fundamental topics ranging from the fetus and the newborn to in vitro fertilization and clonal man, from genetics and family law to eugenics, ethics, law and society; 544 pages—$22.50.

Northwestern University Cancer Center will present the Second Annual Postgraduate Seminar in Oncology, THE MANAGEMENT OF COMMON NEOPLASMS: Head, Neck, Gynecological and Urological Tumors, October 21-23, 1976

at

Northwestern Memorial Hospital
Passavant Pavilion
Offield Auditorium
303 East Superior Street
Chicago, Illinois

Fee for the 2½-day Conference will be $150 for practicing physicians; $75 for fellows and house officers.

The Conference is limited to 100 applicants.

Questions regarding the Conference may be addressed to John S. Schweppe, M.D., Northwestern University Cancer Center, 303 East Chicago Avenue, Chicago, Illinois 60611, or telephone 312-642-9294.

The Woman's Auxiliary Reports to ISMA

Gone but not forgotten is the 53rd annual AMA Auxiliary convention in Dallas. I was very proud, happy, and excited to be representing Indiana as your ISMA Auxiliary presidential delegate during our country's Bicentennial.



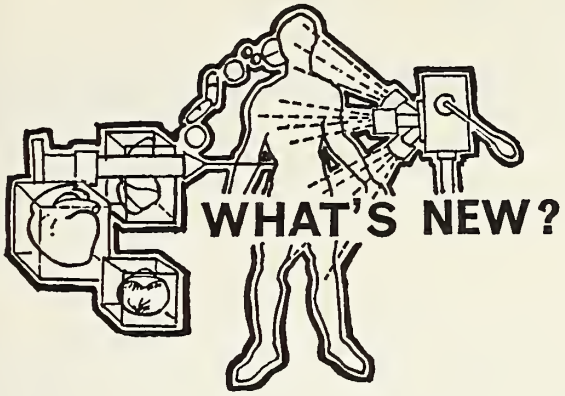
During the year Mrs. Erle Wilkinson, the AMA Auxiliary immediate past president, shared the idea of unity—unity in working together as volunteers at the national, state, and county levels for the common cause of medicine, thus assisting our physician husbands. This "unity is uniqueness" might also be the description of the reports of the state presidents as they spoke of their various auxiliaries' devotion to the causes of health care, community service, and continuing medical education; others of community blood drives; some others of political support for the continued free practice of medicine. All voiced concern for the health of their communities and most mentioned concrete projects for the improvement thereof. "Doctors' wives," they continued to say, "**do** care about **people**."

Many state auxiliaries mentioned participation in community health fairs; most efforts were slanted toward illustrating auxiliary concerns of education and philanthropy. Fund raising for community projects, scholarships and AMA-ERF again were prominent. Visual screening programs, blood pressure drives and blood donorship were emphasized nearly nationwide. Senior citizen projects proved successful and many were concerned with education on safety, emergency first aid and child abuse.

All these reports did prove that, nationwide, DOCTORS' WIVES CARE.

Chloe A. Goldsmith

Chloe (Mrs. David A.) Goldsmith
President, ISMA Auxiliary



Warner Chilcott is introducing the first completely disposable, pre-evacuated vacuum system for uterine aspiration curettage. Each unit is complete with a flexible plastic cannula/curette and VAKUTAGE 110 is precharged with sufficient vacuum to complete endometrial biopsy, menstrual induction and uterine curettage. VAKUTAGE 355 is for completion of a spontaneous incomplete abortion.

* * *

The 3M Company is introducing wider and longer Steri-Strip Skin Closures for use in large abdominal incisions and orthopedic wounds. The increased surface area of the strip offers maximum support for large wounds.

* * *

Schering has released a new oral agent, called Proglycem, for treatment of certain forms of organic hypoglycemia. It acts by inhibiting release of insulin from the pancreas, with benefits within an hour and lasting up to eight hours. Proglycem has no effect on blood pressure.

* * *

The Ames Company, Elkhart, has a unique test kit which may be used in the doctor's office to screen for gonorrhea by culture method. The kit does not require refrigeration and has a shelf life of 18 months. Each kit provides materials for 10 tests.

* * *

Organon is introducing HEXADROL® (dexamethasone sodium phosphate USP) in sterile disposable syringes. Each syringe will contain dosage equal to 4.0 mg. Indications include all those usual for such a steroid but especially indicated are those indications involving acute allergic states which demand prompt therapy.

* * *

Burch Manufacturing Company announces a new, lightweight, collapsible immersion tank designed to meet the critical need for immediate treatment in cases of malignant hyperpyrexia. Weighs only 10 lbs., can be set up in eight seconds by one person, fits a standard stretcher cart. It is easily cleaned and folds up for compact storage.

* * *

Endo Laboratories announces a new indication for Symmetrel® (amantadine hydrochloride). It is now indicated in the treatment of drug-induced extrapyramidal reactions. Symmetrel has been approved previously for Parkinsons's disease and syndrome and for prophylaxis in A2 (Asian) influenza.

* * *

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FUTURE MEETINGS, SEMINARS, COURSES

Dr. Harold Levine to Be Second Annual Arthur B. Richter Lectureship Speaker

The Second Annual Arthur B. Richter Lectureship with guest speaker, Harold D. Levine, M.D., will be held on Wednesday, Sept. 29, at St. Vincent Hospital, Indianapolis. The meeting will open at 8:30 a.m. The morning session will feature a film "Angina Pectoris" narrated by Dr. Samuel A. Levine and with comments by Dr. Harold Levine. Dr. John C. Bailey will discuss "The Antiarrhythmic Properties of Magnesia: A Microelectric Study." Dr. Charles M. Clark, Jr., will talk on "Studies on the Development of Hormonal Responses in the Heart." Dr. Michael L. Smith will discuss "Use of Beta-Blockers in Essential Hypertension." Dr. Donald A. Rothbaum will discuss "Nuclear Cardiology in the Evaluation of Coronary Artery Disease."

Luncheon, for which reservations are requested, will be served in a tent on the hospital grounds. Dr. Levine will discuss "Some Vignettes on Samuel A. Levine, M.D."

In the afternoon session Dr. Levine will talk on "Viral Myocarditis: Its Emerging Importance," and after a coffee break will participate in a Clinical Conference and Case Presentation.

A dinner meeting, for which reservations are requested, will be at Meridian Hills Country Club. After dinner Dr. Levine will speak on "Smallpox, Herpangina and Country Practice."

There is no fee for the clinical program. The luncheon charge is $4.00. The dinner charge is $15. Payment for the meals and reservation requests are to be sent to the Department of Medical Affairs, St. Vincent Hospital, 2001 W. 86th St., Indianapolis 46260.

Course in Professional Corporations And Money Management Announced

The complexities of the professional corporation and efficient money management will be explored at a two-day course offered by the Indiana University School of Dentistry at the Airport Hilton Inn, Indianapolis, Oct. 23 and 24.

Harvey Sarner, an attorney in private practice in Chicago who also serves as an instructor in Dental Jurisprudence at the I. U. School of Dentistry, will conduct the course, for which the fee is $100 for doctors and $35 for auxiliaries or wives (two luncheons are included).

Further information may be obtained by writing to Dr. Robert H. Derry, Director of Continuing Education, I.U School of Dentistry, 1121 W. Michigan St., Indianapolis 46202.

Cancer Symposium Honors Dr. Egan

The Second Annual Mid-American Breast Cancer Symposium will be held Nov. 5 and 6 in Madison, Wis., at the Concourse Hotel. Dr. Robert Egan, formerly of Indianapolis, now of Emory University, one of the pioneers in mammography, will be especially honored. Write William B. Hobbins, Wisconsin Breast Cancer Detection Foundation, Inc., 7803 Mineral Point Road, Madison, WI 53717.

Food Allergy Symposium in Canada

An International Food Allergy Symposium, sponsored by the American College of Allergists, will be held Oct. 13-15 at the Four Seasons Sheraton Hotel, Toronto, Ontario, Canada. For information, write or call Frances P. White, 2141 Fourteenth St., Boulder, Colo. 80302; phone 303-447-8111.

Methodist Hospital Schedules Courses

Courses to be given by the Methodist Hospital, Indianapolis, Graduate Medical Center, have been announced, as follows:

Date	Lecture/Program/Speaker	Place
Sept. 17	Schizophrenia/Dr. Silvano Arieti	Hospital
Sept. 17-18	Surgical Stapling Devices/Dr. Robert Condon	Hospital
Sept. 22	Genetics in Medical Practice/ Dr. Laird Jackson	Hospital
Sept. 22	Fetal Monitoring/Dr. Barry Schifrin	Stouffer's
Sept. 28-29	Perinatal Lecture/Dr. Giulio J. Barbero	Hospital
Oct. 20-21	Current Concepts in Critical Care/ Dr. Jeremy Swan	Stouffer's
Oct. 21	Use of Transcendental Meditation in Hypertension/Dr. Barry Blackwell	Hospital
Oct. 22	New Treatment Approach to Psychosomatic Medicine/Dr. Barry Blackwell	Hospital

The cancer symposium, previously scheduled for September at Clarksville, has been canceled.

Further information may be obtained from the Coordinator of Continuing Medical Education, Methodist Hospital GMC, 1604 N. Capitol Ave., Indianapolis 46202.

Conference on Social Issues in Medicine Scheduled for French Lick In October

"Medicine and the Public" is the theme of the conference on social issues in medicine that has been scheduled for Oct. 8-10 at the French Lick Sheraton Hotel. Co-sponsored by the Poynter Center at Indiana University and the Bloomington Hospital, the conference is intended primarily for Indiana physicians and is approved for Category 1 credit towards the PRA award. Application has been submitted for elective hours to the AAFP.

Major presentations at the conference will be made by Dr. Jean Creek, Bloomington; Professors William May, David H. Smith, Department of Religious Studies, Indiana University; and Roger Dworkin, professor of law, Bloomington.

There is no registration fee for the conference and participants are invited to bring their families. For further information write or call Mrs. Linda Bernstein, The Poynter Center on American Institutions, 410 N. Park St., Bloomington 47401; 812-337-0261.

Symposium on Polytomography Of Temporal Bone Announced

The 15th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, on Nov. 6 and 7, 1976. This continuing Medical Education activity is acceptable for 12 credit hours in Category 1 for the AMA Physician's Recognition Award (PRA).

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technic of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 20. Fee for the course is $250.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis, 46219.

Common Neoplasms Subject of Seminar

Northwestern University Cancer Center will present the Second Annual Postgraduate Seminar in Oncology, The Management of Common Neoplasms: Head, Neck, Gynecological and Urological Tumors, Oct. 21-23, 1976, at Northwestern Memorial Hospital, Passavant Pavilion, Offield Auditorium, 303 East Superior St., Chicago, Illinois.

Fee for the 2½ day Conference will be $150 for practicing physicians; $75 for Fellows and house officers.

Registration is limited to 100 applicants.

Questions regarding the conference may be addressed to John S. Schweepe, M.D., Northwestern University Cancer Center, 303 East Chicago Ave., Chicago 60611, or telephone 312-642-9294.

Cardiac Symposium in January in Arizona

The Arizona Affiliate of the American Heart Association will sponsor its 20th Annual Cardiac Symposium at Mountain Shadows Resort Hotel, Scottsdale, on Jan. 21 and 22, 1977. Registration fee for two days, including lunches, will be $60. For full information write the Affiliate at 1445 E. Thomas Road, Phoenix 85014.

Office Management of Emotional Problems Subject of One, Two, Three-Week Courses

"Mini-residencies" for medical and surgical practitioners in office management of emotional problems are offered by the University of Kentucky Medical Center in one, two, and three-week courses. Minimum of 40 hours per week.

The objective of this program is to give physicians an ideal emotional counseling technic that fits busy office practices. The technic uses a concept of emotions that is consistent with human anatomy and psycho-physiology. Yet, the technic requires no more physician time or patient cost than routine evaluations of new patients. Finally, the technic is readily understandable and easy for practitioners to apply, according to the announcement of the course.

Tuition fee: $350 per week for the first and second week of training; $500 for the third week of supervised practice with patients in the Intensive RBT Treatment Program.

For further information, write Maxie C. Maultsby, Jr., M.D., Office of Continuing Education, RBT Department, University of Kentucky, Lexington 40506.

Course in Emergency Medicine Scheduled at Indianapolis in May

An emergency Medicine Seminar will be conducted by the Indiana Chapter of the American College of Emergency Physicians, with Indiana University School of Medicine as co-sponsor, at the Airport Hilton Inn, Indianapolis, May 11 through 14, 1977. Write David Gettle, M.D., 10005 Hillsdale, Carmel, IN 46032.

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Additions to Roster

The following names, addresses and specialties should be added to your 1976 Roster of Members. These pages may be easily removed by creasing *The Journal* before and after this 4-page section and then carefully pulling it out. It may then be stapled to your Roster for ready reference.

Allen County

Ernest Anderson, 1601 E. Paulding Rd., Fort Wayne 46816 (GP)
Lowell E. Becker, 119 W. Rudisell Blvd., Fort Wayne 46807 (CHP)
Gilbert H. Bierman, 717 Broadway, Fort Wayne 46802 (ORS)
Garland R. Brown, 5522 W. Hamilton, Fort Wayne 46804 (R)
William B. Carr, 5717 S. Anthony, Fort Wayne 46806 (FP)
H. Sayler Daughtery, 102 Medical Center Bldg., Fort Wayne 46802 (OTO)
Dean D. Dauscher, 5717 S. Anthony, Fort Wayne 46806 (GP)
Richard G. Fullam, 5800 Fairfield, #150, Fort Wayne 46807 (AN)
James C. Graham, 1834 S. Lafayette, Fort Wayne 46803 (GP)
Richard C. Haller, 3124 E. State Blvd., Fort Wayne 46805 (N)
George D. Joslin, 227 E. Washington Blvd, Fort Wayne 46802 (P)
John P. Martin, 105 Three Rivers North, Fort Wayne 46802 (AN)
Michael J. Mastrangelo, 2828 Fairfield Ave., Fort Wayne 46807 (GS)
McCallister, John W. 3124 East State Blvd., Fort Wayne 46805 (GS)
James R. Mensch, 2120 Forest Park Blvd., Fort Wayne 46805 (AN)
Don E. Miller, 2828 Fairfield Ave., Fort Wayne 46807 (IM)
Wayne S. Miller, 2828 Fairfield Ave., Fort Wayne 46807 (GS)
John N. Pasalich, 6211 Covington Rd., Fort Wayne 46804 (R)
Walter D. Pepple, P.O. Box 107, Auburn 46706 (GP)
Alan D. Richard, 4535 Spatz Ave., Fort Wayne 46805 (GP)

Bartholomew-Brown County

Carroll F. James, Hope Medical Center, Hope 47246 (GP)
Duane A. Sebahar, 2760 25th St., Columbus 47201 (IM)

Boone County

Gerald E. Fisher, 324 W. North St., Lebanon 46052 (GP)

Cass County

Ruben A. Calisto, U.S. 24 West, Logansport 46947 (GP)
Edwin R. Luxenberg, 8 Chase Pk., Logansport 46947 (PD)

Clark County

Gordon L. Gutmann, 207 Sparks Ave., Jeffersonville 47130 (GS)

Clay County

Forrest R. Buell, 314 Lankford St., Clay City 47841 (GP)

Daviess-Martin County

James P. Beck, 1312 Bedford Rd., Washington 47501 (IM)
Thomas W. Davis, P.O. Box 270, Washington 47501 (FP)
E. Briscoe Lett, 404 John F. Kennedy Ave., Loogootee 47553 (GP)

Delaware-Blackford County

Francis J. Capobianco Jr., 2401 University Ave., Muncie 47303 (FP)
Merlin K. Coulter, 2300 Gilbert, Muncie 47303 (FP)
Frederick J. Fiederlein, 2809 Godman Ave., Muncie 47304 (N)
Larry L. McCallister, 2518 Rosewood, Muncie 47304 (GP)
Paul S. Pentecost, Student Health Center, Muncie 47306 (AN)
Warren E. Stibbins, 2605 Wheeling Ave., Muncie 47304 (GP)

Dubois County

Thomas C. Brown Jr., St. Joseph's Hospital, Huntingburg 47542 (R)
Manuel Fajardo, P.O. Box 126, Ferdinand 47532 (GP)
German Gutierrez, Southern Hills Mental Health, Nonte Building, Jasper 47546 (P)
Andrew B. Lowry, Huntingburg Clinic, Huntingburg 47542 (GP)

Elkhart County

Romney W. Ashton, 29382 Channel View, Elkhart 46514 (R)
Bruce A. McArt, 1332 W. Indiana, Elkhart 46514 (GS)
Floyd L. Rheinheimer, Box 128, Milford 46542 (GP)
John C. Stewart, 2600 Oaklawn Ave., Elkhart 46514 (P)

Fayette-Franklin County

Leticia M. Manuel, 124 E. Sixth St., Connersville 47331 (PD)
Warren D. Pope, Box 46, RR #1, Connersville 47331 (OM)

Floyd County

Thomas M. Jones, 2580 Charlestown Rd., New Albany 47150 (OTO)

Grant County

Rohan Tiruchelvam, 2785 N. Valhalla Dr., Marion 46952 (AN)

Hendricks County

Carl L. Heinlein, 155 W. Marion St., Danville 46122 (GP)

Henry County

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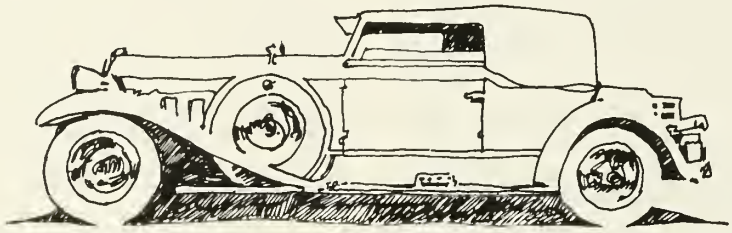
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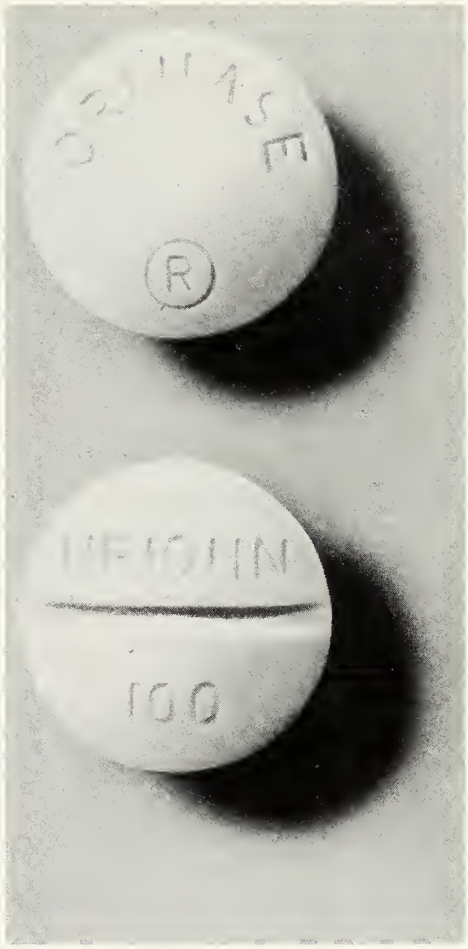
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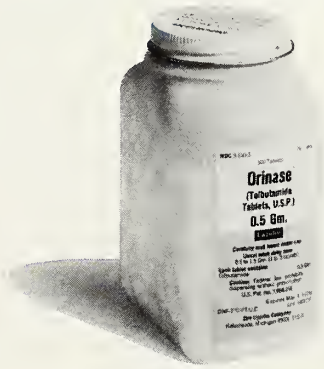
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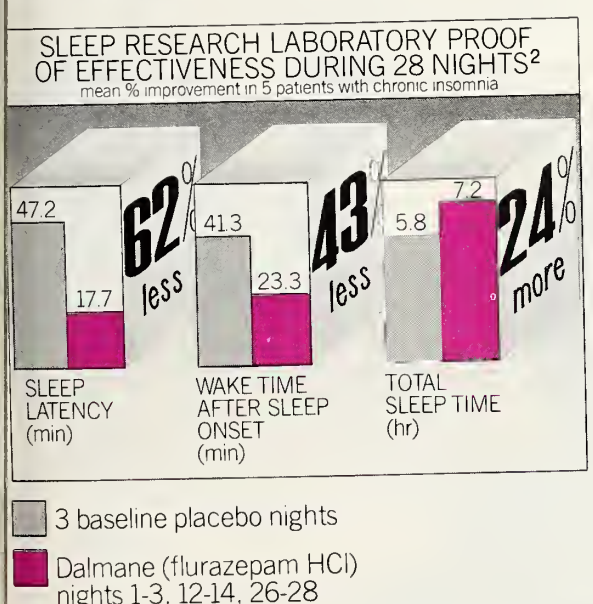


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Please see following page for a summary of product information.

New objective proof: continued insomnia relief without increasing dosage...[1,2]

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Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; and in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Use in women who are or may become pregnant only when potential benefits have been weighed against possible hazards. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, initial dosage should be limited to 15 mg to preclude oversedation, dizziness and/or ataxia. If combined with other drugs having hypnotic or CNS-depressant effects, consider potential additive effects. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported were headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase. Paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, have also been reported in rare instances.

Dosage: Individualize for maximum benefit effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

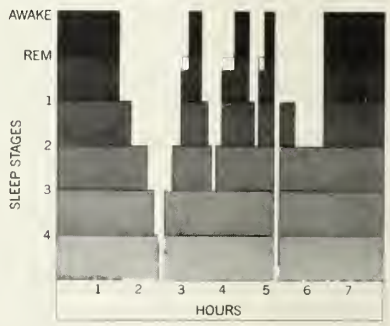
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



REFERENCES:

1. Kales A, *et al*: *Clin Pharmacol Ther 18*:356-363, Sep 1975
2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
3. Kales A, *et al*: *Arch Gen Psychiatry 23*:226-232, Sep 1970
4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

For all common types of insomnia



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From the *Transactions of the Indiana State Medical Society*
100 Years Ago

G. W., of Howard county, Indiana, now about 40 years old, bachelor, afflicted with marked unprogressive posterior dorsal curvature of the spine, small and delicate in conformation, was subjected by me to median lithotomy January 11th, 1875, at the City Hospital, Indianapolis, in the presence of several physicians of this city.

There was a history of youthful onanism only. . . .

The first stone removed, as well as formed, probably dates, for its appreciable formation, to 19 years before the operation (October, 1856), at which time he suffered from some very great cystic irritation (followed by simple left orchitis) which never entirely left him, and which, I believe, after continuing about five years, led to the production of the posterior dorsal spinal curvature, by the intense reflex effect upon the spinal nerves, and the muscles supplied by the irritated portion of the spinal cord. This calculus hung unquestionably from the right side of the dome of the bladder by having one-eighth inch of the extremity of its pedicle imbedded in the mucous membrane of the bladder. . . .

There was such irritability, with proneness to bleed upon the introduction of instruments, that lithotrity was certainly inadvisable. . . .

Previously to the lithotomy, he retained urine usually a half hour; since, he has been able, at times, to retain it for from four to six hours, without distress, and in proportionate quantity. . . .

During the period following his recovery from the surgery, he took, to relieve the cystic irritation, tincture chloride of iron, with good temporary effect, and then benzoic acid, alternated with arsenic, without much benefit. Subsequently he found much temporary relief, and had less formation of "sand" which had somewhat recurred, and yet troubles him (May 13, 1876), from the use of salicylic acid; but this remedy lost its good effect after a few weeks. . . . **"A Case of Lithotomy with Peculiar Features," L. D. Waterman, M.D., Indianapolis, 1876.**

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Control-o-fax has a Fair Credit Billing Act Insert for sale in quantities. The insert is a printed explanation of the customer's new rights under the Fair Credit Billing Act. The Act requires creditors to notify their debtors about their rights under the law. The insert satisfies the requirements concerning notification.

* * *

Ag-Met Inc., manufacturer of silver reclamation units, announces the "Mini Tronic," a compact portable unit designed for use with hand tanks and small automatic processors in doctors' offices. It will remove silver from fixer solution automatically, thus salvaging valuable metal and also extending the life of the fixer.

* * *

Diode B.V. of Utrecht, the Netherlands, has a new, easy-to-carry electronic device which allows vocally-handicapped persons to communicate their desires and thoughts. It resembles and is about the size of a pocket calculator. Has the alphabet, figures 1 to 9, plus, minus and equal signs and the colon. The display panel takes nine characters at a time and drops one off as a new sign is added. May be read by person sitting opposite the patient.

* * *

The Ealing Corporation has a new highly sensitive nurse-call switch for use by patients with limited or no use of their hands. It consists of a large soft sponge encasing a very sensitive switch which is activated by the slightest pressure.

* * *

Doubleday is releasing a paperback "Home Canning: The Last Word." Canning instructions, to be reliable and safe, must be changed regularly. The new low-acid tomatoes require new canning methods to avoid botulism. For the increasing number of home canners the book will supply all the old tried and true methods and all the most recent ones too. Priced at $2.95—126 pages.

* * *

Sherwood Medical has a new endotracheal tube incorporating a high-volume, low-pressure cuff designed for long term ventilatory support as well as for surgical intubation. Trade-marked "THE SOFT ONE" ARGYLE[R] endotracheal tube. The tube is soft and pliable but has non-kinking properties to maintain patency.

* * *

Whitney Marine makes adult tricycles, racing bicycles and industrial vehicles. Their one-passenger and two-passenger tricycles both have bucket seats and may be utilized by patients who are not able to ride a conventional three-wheeler. What started out as a recreational vehicle is now being adapted also to the use of handicapped patients.

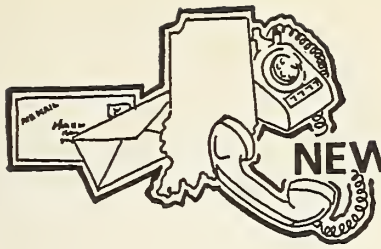
* * *

Hawthorn Books has released "Post-Mastectomy: A Personal Guide to Physical and Emotional Recovery." Written by Win Ann Winkler, the beneficiary of a modified radical mastectomy herself, the book provides practical guidance, understanding and down-to-earth suggestions for patients in a similar situation. 197 pages—$7.95.

* * *

Brentwood Publishing has just released a new book, "Medical Thermography, Theory and Clinical Applications." It contains information from various specialties on the use of thermography. It also discusses the principles of thermography and describes the apparatus and instruments. 196 pages—$37.50.





AMA Has Bibliographic Search Capacity

The American Medical Association, through the facilities of the Division of Library and Archival Services, now has the capability to provide computerized searches of literature in the health sciences through the MED-LINE system of the National Library of Medicine. Searches can be made from the following files:

MEDLINE	(journal literature)
CATLINE	(books)
SERLINE	(serials information)
SDI-LINE	(journal literature, current month)
CANCERLINE	(cancer literature)
TOXLINE	(toxicology literature)

Using simple Boolean logic, special subsets of references on file may be accessed. For example, a recent MEDLINE search requested all journal articles that dealt with psychiatric, problem oriented medical records and computers. This search resulted in a list of 7 current articles.

Books and journal articles are indexed using the categories listed in the National Library of Medicine's Medical Subject Headings (MESH) published in Vol. 17, No. 1, Part 2, January 1976, *Index Medicus*.

Computer searches are provided free of charge to members of the American Medical Association and are $15.00 for nonmembers. In addition to the search, the AMA Library also provides photocopy reprints of journal articles. The cost for this service is 10¢ per page copied in addition to a $3.00 minimum handling charge.

Requests for literature searches or photocopies of medical computing material should be addressed to Associate Editor, Computers and Medicine, 535 N. Dearborn St., Chicago, IL 60610. Requests for non-medical computing related material should be directed to the AMA Division of Library and Archival Services at the same address.

Alaskan Seminar Program Varied

Twenty Hoosier physicians participated in the Alaskan Medical Seminar program July 3 to 12.

Speakers and their subjects were **Dr. Albert J. Miller,** "Collection and Interpretation of Pap Smears"; **Dr. King S. Jones,** "Criteria for Hospital Admission of Patients with Acute Gastroenteritis"; **Dr. G. W. Applegate,** "Chronic Renal Disease"; **Dr. Harold D. Caylor,** "Hyperparathyroidism"; **Dr. Herbert A. Lautz,** "Allergy of the Nose and Throat—Some New Approaches with Sublingual Therapy," and **Dr. Lester D. Bibler,** "New Programming—The HEW Inspector General."

Others attending were **Drs. John L. Arbogast, Lawson Clark,** E. J. DeGrazia, **Edward Dieroff, George Ellis, John Higgins, Richard Logan,** Agatha W. Mootz, **Arthur Payne, C. N. Steussy, Lloyd Terry, Daniel Tweedall, Donald Vivian and Wendell Weller.**

Leukemia Research Grants Announced

The Leukemia Society of America will receive applications for the award of grants for leukemia research. Deadline is October 1. For full details write Dr. Rose Ruth Ellison, in care of the Society, 211 E. 43rd St., New York City, 10017.

Receives 50-Year Award of Gold

Dr. Roscoe S. Yegerlehner, West Lafayette, was honored by the Clay City Masonic Lodge recently in celebration of his 50 years of membership. He received the 50-Year Award of Gold at ceremonies on July 3.

FDA to Spend $16 Million In New Drug Surveillance

The FDA is preparing to organize a comprehensive program to monitor the conduct of tests by the drug industry to determine the safety of human drugs and additives. Authorized by a recent law is a $1 million-plus fund to carry the project until Oct. 1. After Oct. 1 FDA will have some $15.2 million and over 400 new personnel positions for monitoring the drug tests.



CELEBRATES ONE HUNDREDTH YEAR—The Madison County Medical Society celebrated its 100th year in 1975 at the annual President's Ball recently and honored new professionals. The society encourages young doctors to come to Madison County as it launches its second century. **Dr. Ted Doles,** society president, honored **Dr. Suel Sheldon** as the society's 100th president and outgoing officer. Dr. Doles is pictured left acknowledging others in the medical field: from left, Miss Barbara Gene Cler, Pendleton, freshman medical student at Indiana University; Dr. Sheldon, and **Dr. Gordon Wilder,** who was honored for his 50 years in medicine. (Photo by John Cleary, *Anderson Herald)*



DISCUSS HEALTH CARE COSTS ON TV—An hour-long program on Rising Health Care Costs was presented on Channel 6, Indianapolis, on July 21. Among the participants were (left to right): Robert Jones, senior vice president, Blue Cross/Blue Shield; Robert van Hoek, medical director of Wishard Memorial Hospital; Donald F. Foy, executive director, ISMA; **Dr. John W. Beeler,** president-elect, ISMA, and Judy Waugh, Channel 6.

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Continued

Bureau Honors John Twyman

John B. Twyman, Lake County Medical Society executive director, was named outstanding director of 1975 at the recent annual meeting of the Better Business Bureau of Northwest Indiana.

New Hospital Fire Protection Course

The National Fire Protection Association has a slide course on hospital fires for sale at $30 complete with 29 slides and instructor's manual. It is based on a fire which occurred in a modern one-story 43-bed hospital in Osceola, Mo. in which eight patients died. The deaths are said to have resulted from a series of poor decisions long before and during the fire—mattresses with deadly combustion products, delay in notifying fire department, failure to close doors to patients' rooms, inadvertent shutting off of oxygen supply vital for one patient outside the fire area. Address the Association at 470 Atlantic Ave., Boston, 02210.

Radiologist Moving to Fort Wayne

Dr. Robert W. Currie, former Indianapolis radiologist, announces his semi-retirement and will reside at 7106 Bohnke Drive, Fort Wayne 46805. He will be available for part time locum tenens work in diagnostic radiology in the Indiana area. Telephone 219-749-2592.

Medical-Legal Aspects of Health Care Discussed on Audiotape Cassettes

Teach'em, Inc., of Chicago has six audiotape cassettes on the medical-legal aspects of health care. The tapes were produced by the American College of Legal Medicine. Each tape presents two subjects. One subject is "Indiana Malpractice Legislation" by **Dr. Gilbert Wilhelmus.** For full information write to Teach'em at 625 N. Michigan Ave., Chicago, 60611.

Appointed VA Academic Medicine Chief

Dr. Donald L. Custis, retired surgeon general of the Navy, has been appointed deputy assistant chief medical director for academic affairs in the Veterans Administration. Dr. Custis is a native of Goshen, Ind., graduated from Wabash College, and in 1942 received his M.D. degree from Northwestern University.

Writes Bicentennial Articles

Dr. Robert M. Seibel, Nashville, whose article on medical care during the Revolutionary War appeared in the July issue of this journal, has had two other articles of Bicentennial interest published recently. One on Masonic participants in the Revolutionary War is in two parts, one of which appeared in the October 1975 issue of *The Freemason;* the other part is scheduled for publication sometime this fall.

Dr. Joseph Mason Warren, a Boston physician who had been commissioned a major general in the militia three days earlier and performed many feats of bravery before he died in action at the Battle of Bunker Hill, is the subject of an article by Dr. Seibel in the June 1975 issue of *The Indiana Freemason.*

Indiana Medical Foundation, Inc.

Established by the Indiana State Medical Association for educational and scientific purposes, including an endowment fund for publication of **The Journal.**

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code.

Bequests, legacies, devises, transfers or gifts to the Foundation are deductible for Federal estate and gift tax purposes.

The Foundation is an ideal recipient of gifts made in memory of deceased friends and relatives. A special Memorial Book is maintained to record such gifts. Special memorial funds may be established within the Foundation to honor individuals.

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Deaths

Evert Lee Burrous, M.D.

Dr. Evert Lee Burrous, 80, died May 12 at Laramie, Wyo., in Ivinson Memorial Hospital.

After serving Bremen as a general practitioner, Dr. Burrous moved to Peru in the early 1930s to specialize in eye, ear, nose and throat work. He practiced at Peru for many years before retiring to Arizona.

He was a former member of the Marshall and Miami county medical societies and of the American Medical Association. In 1966 he was elected to senior membership in the ISMA.

John W. Ferree, M.D.

Graveside services were held at Bluffton for Dr. John W. Ferree of Pleasantville, N.Y., on July 30, 1976. Dr. Ferree died in October 1975 at Pleasantville.

He graduated from the Indiana University School of Medicine in 1932, served an internship in Detroit and residencies in Chicago and Evanston, Ill., hospitals, and practiced at Bluffton with the late Drs. H. D. Brickley, C. H. Mead and O. G. Hamilton from 1935 to 1937. He headed the county medical society for a time.

Dr. Ferree served as Indiana Health Commissioner from 1940 to 1942 and then served as a U.S. Navy medical officer, gaining the rank of commander.

He served subsequently as director of education for the American Social Hygiene Association, associate director of the National Health Council, associate medical director of the American Heart Association and executive director of the National Association for the Prevention of Blindness. In 1968 and 1969 Dr. Ferree was secretary general of the International Association for Prevention of Blindness.

Leo E. Jordan, M.D.

Dr. Leo E. Jordan, 71, Lynn, died Mar. 22, 1976, in Ocala, Calif., where he was spending the winter.

He was in general practice at Lynn following his graduation from the Indiana University School of Medicine in 1931.

He served with the U. S. Army during World War II.

A member of the Randolph County Medical Society, Dr. Lynn was also a member of the American Medical Association.

Jack L. Loudermilk, M.D.

Dr. Jack L. Loudermilk, a former radiologist at Parkview Memorial Hospital, Fort Wayne, died May 1, 1976, at Good Samaritan Hospital, Phoenix, Ariz.

Following his graduation from Indiana University School of Medicine in 1937, he interned at the Indianapolis City Hospital and was in practice at Albany, moving to Fort Wayne in 1948.

Dr. Loudermilk served with the Army Medical Corps during World War II, attaining the rank of captain.

He served as a delegate from Allen County in 1957 and 1958 and was a member of the American Medical Association.

Frank James McGue, M.D.

Dr. Frank J. McGue, 50, died Mar. 24, 1976, at Memorial Hospital, Springfield, Ill.

A graduate of the Indiana University Medical School in 1953, Dr. McGue became medical director at the Indiana State Prison, Michigan City, in 1958. He later left the prison to go into private practice in the area, moving to Herrin, Ill., in 1973. Dr. McGue was on the staffs of St. Anthony and Memorial hospitals, Michigan City.

During World War II he served in the Navy Medical Corps in the Pacific theater.

Dr. McGue was formerly a member of the Lake and LaPorte county medical societies and of the American Medical Association.

Harvey K. Stork, M.D.

Dr. Harvey K. Stork, 84, died May 1, 1976, at home after practicing medicine for 58 years in Huntingburg. He retired in 1974.

He was a graduate of the University of Louisville Medical School with the class of 1915 and interned at St. Mary's Hospital, Evansville.

In 1917-18, during World War I, Dr. Stork served as a first lieutenant in the Army Medical Corps and was the only surgeon on the medical staff of the 55-bed University Hospital in Columbia, S.C.

In 1965 Dr. Stork became a member of the 50-Year Club; he was also a member of the Dubois County Medical Society, the American Medical Association and was a senior member of the ISMA.

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A surgean and patholagists from Mankata and a radiologist fram Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles).

Far additianal informatian, cantact D. H. Gilbert, Wells Municipal Hospital, 400-4th Avenue, S.W., Wells, Minnesata 56097. (507) 553-5904 ar 553-3111.

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WANTED: Copy of book by Drs. Charles N. Combs and Edgar F. Kiser, "One Hundred Years of Indiana Medicine." Write or call The Journal, 3935 N. Meridian St., Indianapolis 46208; 317-925-7545.

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NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

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DEADLINE: Fifth day of month PRECEDING month of issue.

Are You Moving?

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Indianapolis, IN 46208

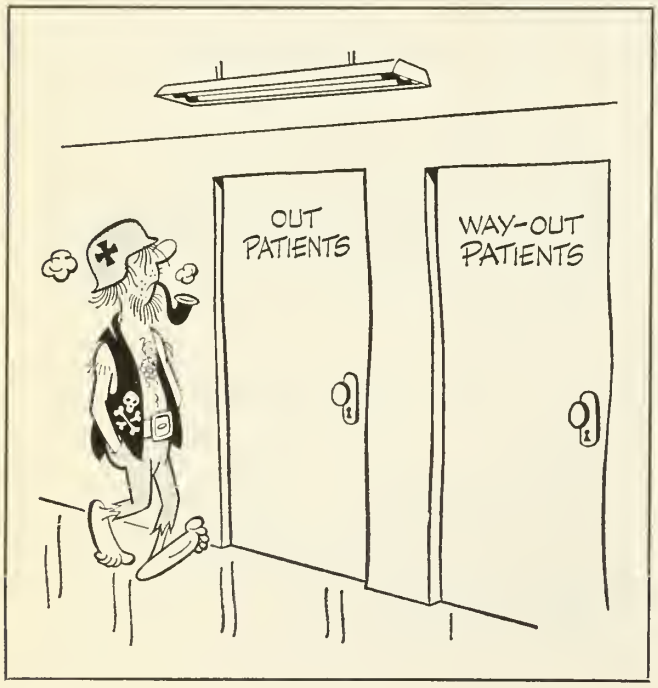
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In accepting advertising for publication, THE JOURNAL has exercised reasonable precaution to insure that only reputable factual advertisements are included. However, we do not have facilities to make any comprehensive or complete investigation, and the claims made by advertisers in behalf of goods, services and medicinal preparations, apparatus or physical appliances are to be regarded as those of the advertiser only. Neither sanction nor endorsement of such is warranted, stated or implied by the association.

127th

Annual Convention

INDIANA STATE MEDICAL ASSOCIATION

October 9, 10, 11 and 12, 1976

All Events on Eastern Standard Time

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Indianapolis

Complete Program and Annual Reports on Following Pages

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Official Call to the House of Delegates

The next annual session of the Indiana State Medical Association will be held at the Indianapolis Hilton Hotel, Indianapolis, Indiana, Oct. 10, 11 and 12, 1976.

The House of Delegates will be constituted as follows: Marion County, twenty-three delegates; Lake County, ten delegates; Allen County, seven delegates; Vanderburgh County, six delegates; St. Joseph County, five delegates; Delaware-Blackford, Owen-Monroe, Tippecanoe and Wayne-Union county societies, each three delegates; Bartholomew-Brown, Daviess-Martin, Dearborn-Ohio, Elkhart, Fayette-Franklin, Fountain-Warren, Grant, Harrison-Crawford, Jefferson-Switzerland, LaPorte, Madison, Parke-Vermillion, Porter and Vigo county societies, each two delegates; the other 58 county societies, each one delegate; fourteen trustees and the ex-presidents—namely, Herman M. Baker, M.C. Topping, Kenneth L. Olson, Earl W. Mericle, Guy A. Owsley, Maurice E. Glock, Donald E. Wood, Joseph M. Black, Eugene S. Rifner, Patrick J.V. Corcoran, Lowell H. Steen, Malcolm O. Scamahorn, Peter R. Petrich, James H. Gosman, Joe Dukes and Gilbert M. Wilhelmus. The American Medical Student Association, one delegate. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be ex officio members; the president, president-elect, the executive director, the treasurer, the assistant treasurer, the speaker, the vice-speaker and the delegates to the American Medical Association, all without power to vote, except in the case of a tie vote, when the president or person presiding shall cast the deciding vote.

All delegates must present their credentials card certified by their county medical society before being seated as a delegate. No delegate will be seated without proper certification.

The House of Delegates will convene promptly at 3:00 p.m., EST, Sunday, Oct. 10, in the Ballroom Centre, Lower Lobby, Indianapolis Hilton, Indianapolis. The final meeting of the House of Delegates will convene at 1:30 p.m., Tuesday, Oct. 12, in the Ballroom Centre.

The order of business will be as follows:

1. Call to order by the president.
2. Invocation.
3. Roll call and seating of qualified delegates.
4. Announcements from the chair.
5. Tribute to members of the House of those who served the association in an official capacity and who have died since the 1975 session.
6. Reading of minutes of previous meetings.
7. Introduction of guests.
8. President's address.
9. Appointment of Reference Committees and assignment of meeting rooms.
10. Unfinished business.
11. Address of president-elect.
12. Report of president of the ISMA Auxiliary.
13. Report of the Indiana Chapter, American Medical Student Association.
14. Report of president of Blue Shield.
15. Report of executive director.
16. Report of treasurer.
17. Report of chairman of the Board.
18. Reports of trustees.
19. Report of *The Journal* editor.
20. Report of AMA delegates.
21. Report of Indiana Medical Licensing Board.
22. Ad Hoc Committee to Supervise Pilot Project on Medical and Health Care in Jails.
23. Reports of committees and commissions.

COMMITTEES

(1) Executive
(2) Grievance
(3) Future Planning
(4) Medical-Legal Review

COMMISSIONS

(1) Commission on Constitution and Bylaws
(2) Commission on Convention Arrangements
(3) Commission on Legislation
(4) Commission on Medical Education
(5) Commission on Medical Services
(6) Commission on Public Relations

24. New Business:
 (1) Matters referred by Board of Trustees
 (2) Matters referred by Executive Committee
 (3) Resolutions
 (4) Selection of city for 1981 meeting
 1977—Indianapolis—Oct. 10-14
 1978—French Lick—Oct. 14-19
 1979—Indianapolis—Oct. 8-10
 1980—Indianapolis—dates to be set by Board of Trustees

The election of officers will be the first order of business at the final meeting of the House of Delegates. In addition to the regular officers, the terms of the following AMA delegates and alternates expire Dec. 31, 1976, and their successors must be elected at the session: Delegates to the American Medical Association to suceed James A. Harshman, Kokomo; John O. Butler, Indianapolis, and Malcolm O. Scamahorn, Pittsboro; alternate delegates to succeed George T. Lukemeyer, Indianapolis; Ross L. Egger, Daleville, and Everett Bickers, Floyds Knobs.

Delegates from the Third, Sixth, Ninth and Twelfth Districts are reminded that the tersm of their trustees will expire Oct. 12, 1976, and new trustees should be elected to succeed the following:

Third—Eli Goodman, Charlestown
Sixth—Paul M. Inlow, Shelbyville
Ninth—William M. Sholty, Lafayette
Twelfth—Alvin J. Haley, Fort Wayne

Some of these elections may already have been held, but they should be reported to the House of Delegates at this session for confirmation.

DONALD F. FOY, Executive Director

HOUSE OF DELEGATES

1976 Annual Meeting
Indiana State Medical Association

County and Delegates	Alternates
ADAMS (1)	
Norval S. Rich, Decatur	Harold Zwick, Decatur
ALLEN (7)	
William R. Cast, Fort Wayne	Robert W. Dettmer, Fort Wayne
Thomas A. Felger, Fort Wayne	James J. Harris, Fort Wayne
DeWayne L. Hull, Fort Wayne	Charles E. Schoenhals, Fort Wayne
Fred W. Dahling, New Haven	David P. Schlueter, Fort Wayne
Marvin E. Priddy, Fort Wayne	Philip C. Schubert, Fort Wayne
Karl R. Schlademan, Fort Wayne	Richard E. Tielker, Fort Wayne
Charles H. Aust, Fort Wayne	Harry D. Tunnell, Fort Wayne
BARTHOLOMEW-BROWN (2)	
C. David Ryan, Columbus	Lindley L. Gammell, Columbus
Robert M. Seibel, Nashville	
BENTON (1)	
Manuel Scheurich, Oxford	
BOONE (1)	
Paul R. Honan, Lebanon	Edwin E. Gregg, Lebanon
CARROLL (1)	
T. Neal Petry, Delphi	Charles L. Wise, Camden
CASS (1)	
Richard L. Glendening, Logansport	Russell J. Morrical, Logansport
CLARK (1)	
David Jones, Charlestown	William Voskuhl, Charlestown
CLAY (1)	
Robert Oehler, Brazil	Everett L. Conrad, Brazil
CLINTON (1)	
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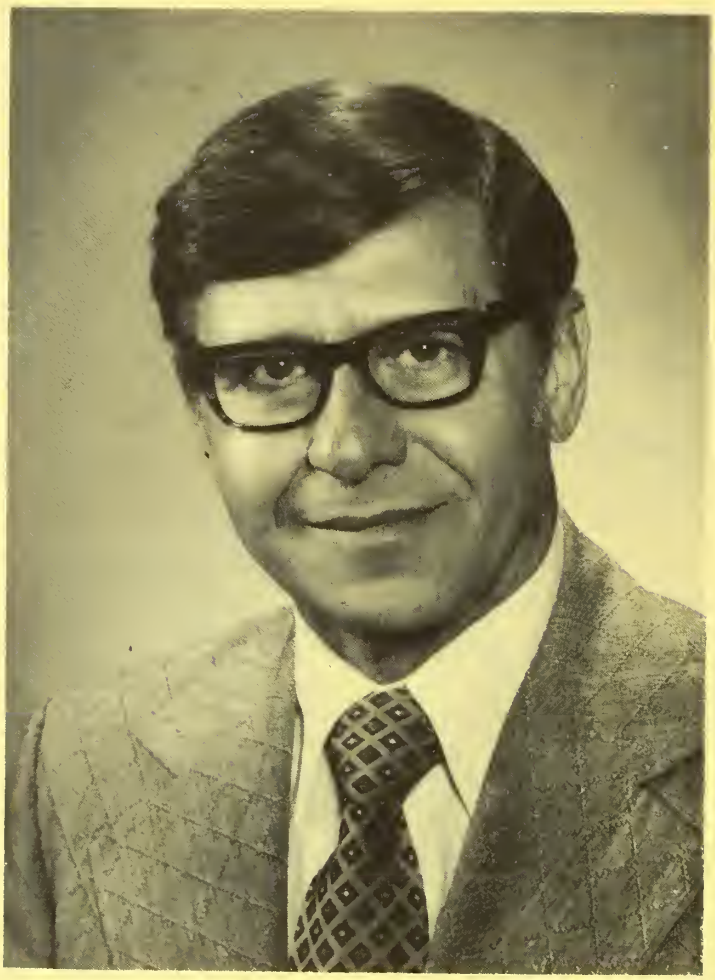
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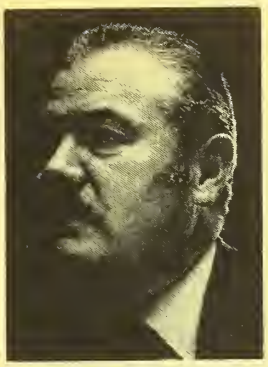
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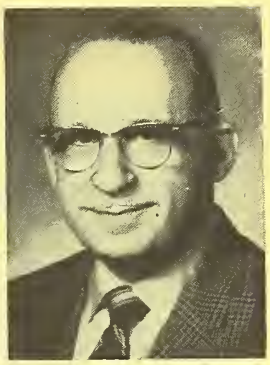
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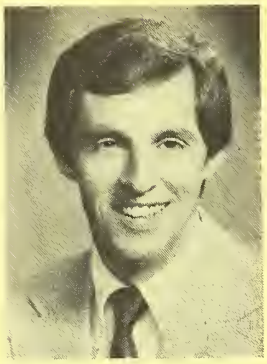
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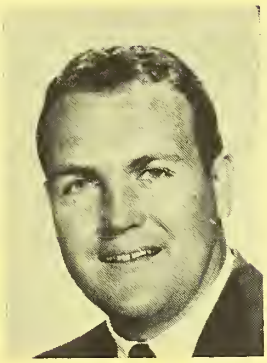
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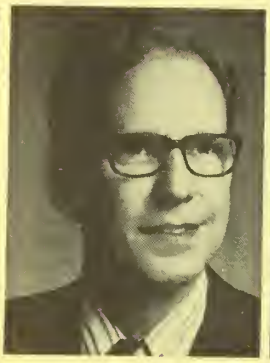
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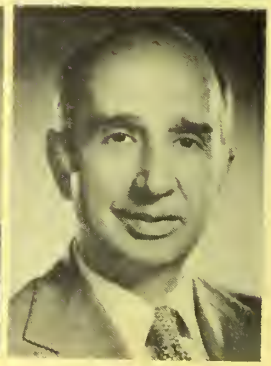
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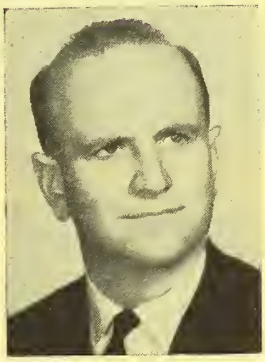
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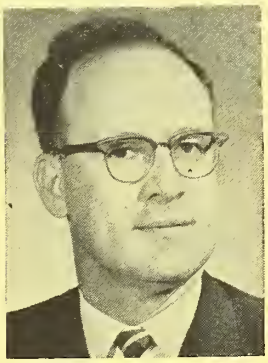
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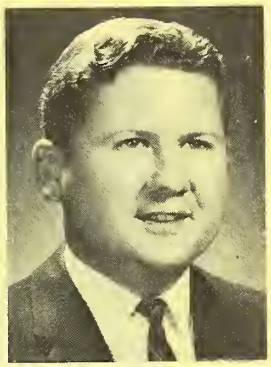
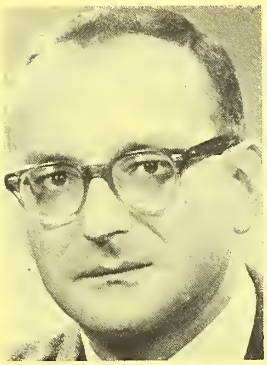
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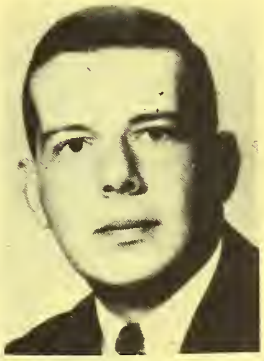
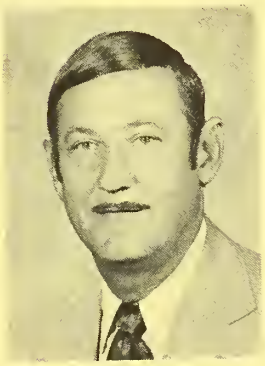
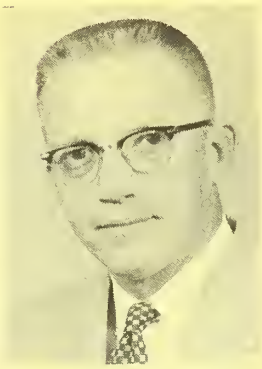
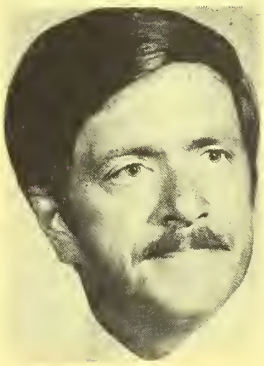
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Dancing to the music of the Joe Frazer Band will follow the President's Dinner on Monday evening, Oct. 11, at the Hilton Hotel.

Schedule of Events

127th Annual Convention
Indianapolis-Hilton
Meridian and Ohio Streets
Indianapolis

(All Events will be on Eastern Standard Time)
(The scientific program for the 127th Annual Convention of the Indiana State Medical Association is acceptable for 14 prescribed and no elective hours by the American Academy of Family Physicians. The prescribed hours are for attendance at the Family Physicians Section meeting.)

(Scientific programs presented at the 1976 ISMA Convention are accredited on an hour-for-hour basis for inclusion in Category 1 of the application for the AMA Physician's Recognition Award. Hours allowable in any given program are shown beside the program listing.)

All meetings will be held in the Indianapolis Hilton, Meridian and Ohio Streets, with the exception of the Board of Trustees Annual Dinner and the Practice Management Program, which will be held in the Columbia Club on Monument Circle.

Saturday, Oct. 9, 1976

7:00 p.m. Board of Trustees Annual Dinner, Columbia Club

7:30 p.m. Board of Directors, Indiana Society of American Association of Medical Assistants, Columbia Club

Sunday, Oct. 10, 1976

9:00 a.m. to 4:00 p.m. PRACTICE MANAGEMENT PROGRAM, presented by Clayton L. Scroggins Associates, Cincinnati, Ohio Columbia Club

9:00 a.m. Registration Begins, Lower Lobby Corridor, Indianapolis Hilton

12:30 p.m. Opening of Scientific Exhibits, Monument Suite and Festival East, Lower Lobby

10:00 a.m. to 4:00 pm. INDIANA SOCIETY OF AMERICAN ASSOCIATION OF MEDICAL ASSISTANTS, Room 928-32
CANCER: A TEAM APPROACH
Luncheon, Festival West and Centre, Lower Lobby

10:00 a.m. ISMA Executive Committee Meeting, Room 942

11:00 a.m. Editorial Board Luncheon, Room 922

12 noon Board of Trustees Meeting (Luncheon) Rooms 939-41

3:00 p.m. House of Delegates Meeting, Ballroom Centre, Lower Lobby

5:00 p.m. Dinner, ASSOCIATION OF AMERICAN PHYSICIANS AND SURGEONS, Festival West, Lower Lobby
Speaker:

7:00 p.m. Reference Committee Meetings
Reference Committee No. 1—Room 942
Reference Committee No. 2—Room 922
Reference Committee No. 3—Room 939
Reference Committee No. 4—Room 941
Reference Committee No. 5—Rooms 928-32

Monday, Oct. 11, 1976

9:00 a.m. Registration Continues, Lower Lobby Corridor
Opening of Scientific Exhibits, Monument Suite & Festival East, Lower Lobby



GLEN LEHMAN, M.D.
Indianapolis

Assistant prafessar of medicine, Indiana University School af Medicine; specialty in gastraenteralogy; member Phi Beta Kappa, Alpha Omega Alpha; M.D. degree fram I.U.



ROBERT L. BAEHNER, M.D.
Indianapalis

Prafessar af pediatrics and clinical pathalogy and director, Pediatric Hematalagy and Oncalagy Divisian, James Whitcomb Riley Haspital far Children; established investigator of the American Heart Associatian and member af the Executive Committee of the Children's Cancer Study Group; M.D. degree from the University af Cincinnati.



JAMES ANTHONY MADURA, M.D.
Indianapolis

Assaciate prafessar of Surgery, I.U. Schaal af Medicine; specialty in surgery; Fellow af American Callege of Surgeans; M.D. degree fram Western Reserve University, 1963.

Monday, Oct. 11, 1976

9:00 a.m. to 12 noon **"MEET THE PROFESSOR"**

(The Department of Medicine of Indiana University School of Medicine has arranged to conduct these Conferences.)
(Possible Hours of Accreditation 3.0 for entire Session.)
Room 922

COLON CARCINOMA WITH EMPHASIS ON
(1) Ca Arising in Ulcerative Colitis
(2) Relationship of Colon Ca and Colon Polyps
(3) Role of Colonoscopy and Air Contrast Barium in Colon Ca Detection
Glen Lehman, M.D., assistant professor of Medicine
Room 942

DIAGNOSIS AND MANAGEMENT OF MALIGNANT DISEASE IN CHILDREN, Robert L. Baehner, M.D., professor of pediatrics and clinical pathology and director, pediatric hematology and oncology division.
Room 939

DIAGNOSIS AND TREATMENT OF MALIGNANT DISEASE IN ADULTS, Lawrence Einhorn, M.D., associate professor of medicine
Room 941

ROLE OF ANTIBIOTICS IN PATIENTS WITH MALIGNANT DISEASES, William L. Hoppes, M.D., assistant professor of medicine

Section on Surgery, Indiana Chapter, American College of Surgeons and Indiana Chapter, International College of Surgeons

(Possible Hours of Accreditation 1.0)
Rooms 928-932

12 noon — Luncheon
12:45 p.m. — Business Meeting and Election of 1977 Section Officers

1:15 p.m. to 2:15 p.m. — RECENT TRENDS IN THE TREATMENT OF BREAST CARCINOMA, James Madura, M.D., associate professor of Surgery, Indiana University School of Medicine, Indianapolis

12 noon — IMPAC LUNCHEON, Royal Centre, Lower Lobby
Speaker:

Monday, Oct. 11, 1976

12:30 p.m. Golf Tournament, Speedway Golf Course, 4440 West 16th Street. (John B. White, Jr., M.D., Indianapolis, chairman.) Tee off times 12:30-2:00 p.m.

1:00 p.m. Meeting of Small County Delegates Room 939

2:00 p.m. to 6:00 p.m. Tennis Tournament, Carmel Racquet Club, 222 E. Carmel Dr., Carmel (Dean Grove, M.D., Indianapolis, chairman.)

GENERAL MEETING

(Possible Hours of Accreditation 2.0)

Royal East, Lower Lobby

John L. Ferry, M.D., Chairman, Commission on Convention Arrangements, presiding

2:00 p.m. Remarks by Vincent J. Santare, M.D., president ISMA

2:10 p.m. to 2:50 p.m. WHAT IS THE ROLE OF THE COMMUNITY HOSPITAL IN THE DIAGNOSIS AND TREATMENT OF CANCER, Thornton C. Kline, Jr., M.D., Rockford, Illinois

2:50 p.m. to 3:30 p.m. USE OF PROTOCOLS IN CANCER THERAPY, Gerald N. Grumet, M.D., Chicago, Illinois

3:30 p.m. to 4:10 p.m. USE OF IMMUNOLOGY IN CANCER, Melvin G. Dodson, M.D., Maywood, Illinois

5:30 p.m. Reception for 50-Year Club
Festival East, Lower Lobby

7:00 p.m. President's Reception
Lower Lobby Corridor

7:45 p.m. President's Dinner
Royal East and Center, Lower Lobby

PRACTICAL APPLICATIONS IN MEDICAL MALPRACTICE, Thomas G. Baffes, M.D., Chairman, Department of Surgery, Mt. Sinai Hospital Medical Center, Chicago

Recognition of 50-Year Club

Response: William R. Clark, Sr., M.D., Fort Wayne

Presentation of Awards

Entertainment by the Nick Kostas Strings during reception and dinner; dancing afterwards to the music of the Joe Frazer Band

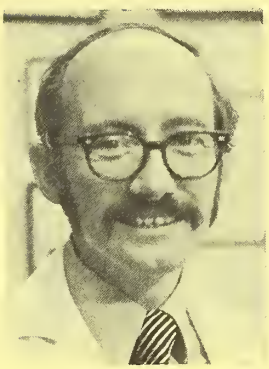
Tuesday, Oct. 12, 1976

8:00 a.m. Breakfast, Phi Beta Pi
Breakfast Dining Room

9:00 a.m. Registration Continues, Lower Lobby Corridor

Opening of Scientific Exhibits
Monument Suite and Festival East, Lower Lobby

12 noon Past President's Luncheon
Entertainment Parlor



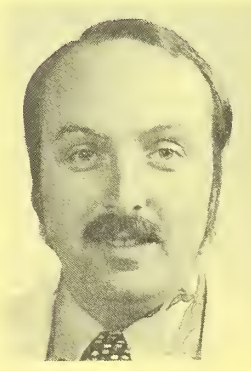
THORNTON C. KLINE, JR., M.D.
Rockford, Ill.

Clinicol ossociote, Rockford School of Medicine ond choirman, Rodiotion Oncology Center for Northern Illinois, Swedish American Hospital, Rockford; specialty in radiotion oncology; M.D. degree from Boston University School of Medicine in 1964.



GERALD N. GRUMET, M.D.
Chicago

Northwestern University Medicol School faculty; speciolty in hematology, oncology; chief, Oncology Section, Veterons Administration Lokeside Hospital, Chicogo; M.D. degree from University of Michigon in 1965.



MELVIN G. DODSON, M.D.
Moywood, Ill.

Assistant professor, Loyolo University Medicol Center, Maywood; in private practice in Miomi, Fla., 1971-1973, and chairmon, Ob/Gyn Department, Miomi Dade County General Hospital; member, Americon College of Obstetricians and Gynecologists; M.D. degree from University of Miomi School of Medicine, 1967.



RICHARD G. FARMER, M.D.
Cleveland

Chairman, Division of Medicine, and head, Department of Gastroenterology, Cleveland Clinic Faundation; specialty in gastroenterology; member Alpha Omega Alpha; Fellow, American College of Physicians; M.D. degree from University of Maryland, 1956.

WILLIAM V. WHITEHORN, M.D.
Silver Spring, Md.

Assistant commissianer for professianal and consumer programs, Food and Drug Administration; farmer professor of health sciences and biological science and director, Division of Health Sciences, and special assistant to the president for medical affairs, University of Delaware; Fellow of American Assaciation for Advancement of Science; M.D. degree from University of Michigan in 1939.





GEORGE T. LUKEMEYER, M.D.
Indianapolis

Professor of medicine and associate dean, Indiana University School of Medicine; specialty in internal medicine; governor, American College of Physicians, Indiana Region; M.D. degree from Indiana University in 1947.

JOHN W. SIGLER, M.D.
Detrait

Chief, Division of Rheumatology, Henry Ford Hospital; clinical associate prafessor of internal medicine, University of Michigan; specialty in internal medicine—rheumatology; Fellaw, American College of Physicians; M.D. degree from University of Maryland.





HERBERT LUBOWITZ
St. Lauis

Associate professor of medicine, Washington University School of Medicine, and chief, Division of Nephrology, The Jewish Hospital of St. Louis; attending physician, Jewish Hospital and Barnes Haspital; specialty in nephrology; member Alpha Omega Alpha; M.D. degree from Washington University.

Tuesday, Oct. 12, 1976

SECTION MEETINGS

Section on Internal Medicine, Indiana Society of Internal Medicine and American College of Physicians
(Possible Hours of Accreditation 6.0)
Royal Centre, Lower Lobby

9:00 a.m.	Welcome, Thomas W. Alley, M.D., Indianapolis
	Moderator—Evart M. Beck, M.D., Indianapolis, president, Indiana Society of Internal Medicine
9:05 a.m. to 9:50 a.m.	INFLAMMATORY BOWEL DISEASE AND THE RELATIONSHIP OF DISEASE LOCATION TO CLINICAL COURSE, Richard G. Farmer, M.D., Cleveland Clinic, Cleveland
	Sponsored by G. D. Searle & Co.
9:50 a.m. to 10:35 a.m.	THE FDA AND THE INTERNIST, William V. Whitehorn, M.D., Rockville, Maryland
	Sponsored by Food and Drug Administration
10:35 a.m. to 10:45 a.m.	Break
10:45 a.m. to 11:30 a.m.	THE INTERNIST'S ROLE IN MEDICAL ONCOLOGY, Lawrence Einhorn, M.D., Indiana University Medical Center, Indianapolis
11:30 a.m. to 12 noon	CURRENT ACTIVITIES OF ASIM, ASIM Representative Mervin Shalowitz, M.D., Skokie, Ill.
12 noon to 12:15 p.m.	Annual Business Meeting Election 1977 Section Officers
12:15 p.m. to 1:15 p.m.	Buffet lunch, Royal East, Lower Lobby
	Afternoon Session Royal Centre, Lower Lobby
	Moderator—George T. Lukemeyer, M.D., Indianapolis, Indiana Governor, American College of Physicians
1:15 p.m. to 1:45 p.m.	CURRENT ACTIVITIES OF ACP, ACP Representative Calvin F. Kay, M.D., deputy executive vice president ACP, Philadelphia
1:45 p.m. to 2:30 p.m.	ANKYLOSING SPONDYLITIS AND RHEUMATOID VARIANTS, John W. Sigler, M.D., Henry Ford Hospital, Detroit
	Sponsored by Merck Sharp & Dohme
2:30 p.m. to 3:15 p.m.	MANAGEMENT OF EDEMA-FORMING STATES, Herbert Lubowitz, M.D., Washington University, St. Louis
	Sponsored by G. D. Searle & Co.

3:15 p.m. to 3:25 p.m. Break

3:25 p.m. to 4:10 p.m. GRAM-NEGATIVE INFECTIONS, Gerald Mandell, M.D., University of Virginia, Charlottesville

4:10 p.m. to 4:55 p.m. THE EVOLUTION OF MEDICAL PRACTICE IN THE U.S.A., TOMORROW'S CHANGES, Yvan Silva, M.D., Detroit General Hospital, Detroit



GERALD L. MANDELL, M.D.
Charlottesville, Va.

Prafessar af medicine and head, Divisian af Infectiaus Disease, University af Virginia Medical Schaal; Fellaw, American Callege af Physicians; member Phi Beta Kappa, Alpha Omega Alpha; M.D. degree fram Carnell.



YVAN J. SILVA, M.D.
Detrait

Assaciate prafessar af Surgery, Wayne State University Schaal af Medicine, and directar af medical educatian at Detrait General Haspital; Fellaw, American Callege af Surgeans; M.D. degree fram University af Bambay in 1960.

Section on Family Practice

(Possible Hours of Accreditation 5.0)

Rooms 939-941

10:00 a.m. SPECIMEN EVALUATION — SPUTUM — NODES, ETC., Robert V. DeRossi, M.D., Indianapolis

11:00 a.m. COLO-RECTAL CA — SCREENING DETECTION, William S. Sobat, M.D., Indianapolis

12 noon Luncheon

Election of 1977 Section Officers

1:30 p.m. RADIOISOTOPE SCANNING — SCREENING AND STAGING OF DISEASE AND PITFALLS IN INTERPRETATION OF BONE SCANS, Larry L. Heck, M.D., Indianapolis

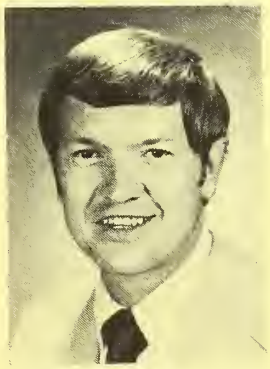
2:30 p.m. A CLINICAL ONCOLOGY PROGRAM FOR THE COMMUNITY HOSPITAL, William M. Dugan, Jr., M.D., Indianapolis

3:30 p.m. Adjournment



WILLIAM S. SOBAT
Indianapolis

Director af Surgery Education, Methodist Haspital; specialty in surgery; M.D. degree fram Indiana University Medical Schaal in 1962.



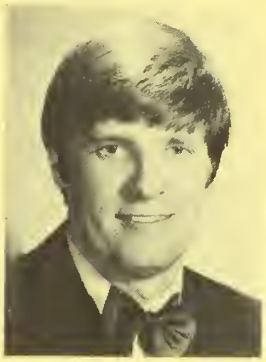
LARRY L. HECK, M.D.
Indianapalis

On faculty af Methadist Haspital Graduate Medical Center; cansultant, U.S. Naval Haspital Nuclear Medicine Clinic, Bethesda; specialty in radiology and nuclear medicine; director, Nuclear Medicine Clinic, Naval Hospital, Bethesda, 1971-73; M.D. degree fram University af Kansas.



WILLIAM M. DUGAN, JR., M.D.
Indianapalis

Assistant clinical prafessar af medicine, I.U. Schaal af Medicine; teaching staff, Methadist Haspital; specialty in internal medicine, hematalagy/oncalagy; Fellaw, American Callege af Physicians; member Alpha Omega Alpha; vice president, Indiana Divisian af American Cancer saciety; M.D. degree fram I.U.



JAMES L. BIESECKER
Indianapolis

On teaching staff of Methadist Haspital; specialty in immunalagy; Fellow in pathalagy, Johns Hopkins Haspital and University, 1967-69, and Memorial Sloan-Kettering Cancer Center, 1969-70; member Alpha Omega Alpha; M.D. degree from Bowman Gray School of Medicine in 1967.



DOUGLAS A. TRIPLETT, M.D.
Muncie

Assistant professor of pathology, Indiano University School of Meoicine, and adjunct professor of physiology and health science, Ball State University; specialty in pathalogy and hemotolagy; member Alpha Omega Alpha; M.D. degree from I.U.



MARK W. BRAUN, M.D.
Muncie

Teaching assistant, Muncie Center far Medical Educatian, and secand year pathalagy resident at Ball Memorial Haspital; M.D. degree from Indiana University in 1975.



EDWIN E. PONTIUS, M.D.
Indianapolis

Clinicol professor of pothalogy, Indiana University School of Medicine; specialty in pathology; chairman, Cancer Committee of Methodist Hospital; M.D. degree from I.U.

Section on Pathology and Forensic Medicine and the Indiana Association of Pathologists

(Possible Hours of Accreditation 5.0)
Room 922

10:00 a.m. to 11:00 a.m. — TUMOR IMMUNOLOGY, Jim Biesecker, M.D., Methodist Hospital, Indianapolis

11:00 a.m. to 12 noon — UNUSUAL CLINICAL FEATURES OF PLASMA CELL DYSCRASIAS, Douglas A. Triplett, M.D., Ball Memorial Hospital, Muncie

12 noon to 1:00 p.m. — Luncheon

1:00 p.m. to 2:00 p.m. — ALTERATIONS IN COAGULATION AND FIBRINOLYSIS ASSOCIATED WITH MALIGNANCIES, Mark Braun, M.D., resident in pathology, Ball Memorial Hospital, Muncie

2:00 p.m. to 3:00 p.m. — FINE NEEDLE ASPIRATION BIOPSY, Robert Ellis, M.D., Bloomington Hospital, Bloomington

3:00 p.m. to 4:00 p.m. — TUMOR REGISTRY IN A COMMUNITY HOSPITAL, Edwin E. Pontius, M.D., Methodist Hospital, Indianapolis

Section on Public Health and Preventive Medicine and Indiana Association of Public Health Physicians, Inc.

(Possible Hours of Accreditation 4.0)
Entertainment Parlor
Ivan T. Lindgren, M.D., president, Indiana Association of Public Health Physicians, Inc., presiding

10:00 a.m. — EPIDEMIOLOGICAL ASPECTS OF ENVIRONMENTAL POLLUTANTS ASSOCIATED WITH CANCER, Dale Morse, M.D., Atlanta, Ga.

12 noon — Luncheon
Business Meeting — Election of 1977 Section Officers

1:30 p.m. — HORMONE REPLACEMENT THERAPY—IMPACT OR NOT ON CANCER, Robert Cleary, M.D., Indianapolis

Section on Radiology and Indiana Roentgen Society

(Possible Hours of Accreditation 1.0)

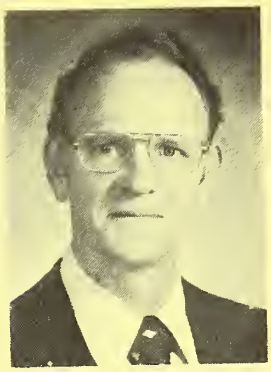
Entertainment Parlor

10:00 a.m. Executive Committee Meeting, Indiana Roentgen Society

11:00 a.m. Business Meeting

12 noon Luncheon

1:00 p.m. ENDOSCOPY AND RADIOLOGY — THEIR LIMITATIONS AND COMPLEMENTARY ROLE IN THE DIAGNOSIS OF CANCER, Glen Lehman, M.D., assistant professor of medicine, Section of Gastroenterology, I. U. School of Medicine, Indianapolis



WILLIAM A. KARSELL, M.D.
Indianapolis

Director Ob/Gyn Program, Methodist Hospital; on staff of Community Hospital; diplomate American Board of Obstetrics and Gynecology; in private practice 25 years; M.D. degree from Indiana University in 1942.

Section on Directors of Medical Educational and Association of Indiana Directors of Medical Education

(Possible Hours of Accreditation 2.0)

Entertainment Parlor

12 noon Luncheon

Panel Presentation—CANCER EDUCATION IN THE COMMUNITY HOSPITAL

Moderator: William A. Karsell, M.D., Indianapolis

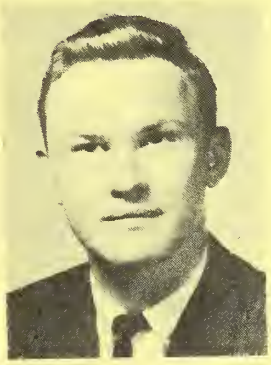
Speakers:

Edwin W. Pontius, M.D., Indianapolis

William M. Dugan, Jr., M.D., Indianapolis

Roger F. Robison, M.D., Bloomington

Business Meeting—Election of 1977 Section Officers



ROGER F. ROBISON, M.D.
Bloomington

In private practice of hematology/oncology at Bloomington since 1969; assistant professor of medicine, Indiana University School of Medicine (Bloomington) since 1970; Fellow, American College of Physicians; specialty in internal medicine; M.D. degree from Albany Medical College of Union University in 1963.

Section on Urology and Indiana State Urological Society

(Possible Hours of Accreditation 4.0)

Room 942

12 noon Luncheon

Business Meeting—Election of 1977 Section Officers

1:00 p.m. PROSTATE CANCER

Moderator—Myron H. Nourse, M.D., Indianapolis

(1) Workup and Staging—Thomas Riley, M.D., Indianapolis; Frank B. Adney, M.D., Richmond

(2) Who Is Operable—Arnold Melman, M.D., Indianapolis; Russell L. Judd, M.D., Indianapolis

(3) Operative Approach—Walter R. Vaughn, M.D., Vincennes; Theodore V. Beutler, M.D., Fort Wayne

(a) Radical Perineal Alone

(b) Nodes First, Then Perineal One Week Later



MYRON H. NOURSE, M.D.
Indionopolis

Associate professor, Department of Urology, Indiana University School of Medicine; Fellow, American College of Surgeons; diplomate, American Board of Urology; M.D. degree from the University of Iowa.



MICHAEL H. THOMAS, M.D.
Indianapolis

Assistant professar, Department af Urolagy, Indiana University Schaal af Medicine; chief af Uralagy Sectian, Wishard Memarial Hospital; diplamate, American Baard of Uralagy. M.D. degree fram Indiana University in 1967.



JOHN P. DONOHUE, M.D.
Indianapolis

Prafessar and chairman, Department af Urolagy, Indiana University School af Medicine; cansultant, Veterans Administratian, Wishard Memarial and St. Vincent Haspitals; Fellaw, American College af Physicians and American Callege af Surgeans. M.D. degree fram Carnell in 1958.

(c) Radical Retropubic and Nodes Simultaneously

1:50 p.m. Break

2:00 p.m. BLADDER CANCER
Moderator—Michael H. Thomas, M.D., Indianapolis

(1) Staging and Grading—Ned P. Rule, M.D., Evansville

(2) How I Manage Stage A Lesions—Donald C. McCallum, M.D.; Edwin C. McDaniel, M.D.; Charles J. VanTassel, Jr., M.D., Indianapolis

(3) How I Manage Stage B-1 Lesions—Daniel M. Newman, M.D.; Philip G. Mosbaugh, M.D., Indianapolis

(4) How I Manage Stage B-2 Lesions—Stafford W. Pile, M.D.; William M. Walton, M.D.; Earl H. Johnson, M.D., Indianapolis

(5) How I Manage Advanced Local Disease (In the Absence of Distant Metastases)—Michael H. Thomas, M.D., Indianapolis; George W. Bowers, M.D., Fort Wayne; Bernard I. Levatin, M.D., South Bend

(6) How Often a Follow-Up Post-TUR Excisional Biopsies—Paul E. Humphrey, M.D.; William L. Veach, M.D.; Pulkit J. Patel, M.D., Terre Haute

3:00 p.m. Break

3:15 p.m. MANAGEMENT OF TESTIS TUMORS
Moderator—John P. Donohue, M.D., Indianapolis

(1) Improved Chemotherapy—Lawrence Einhorn, M.D., Indianapolis

(2) Importance of Tumor Markers—Arthur Sagalowsky, M.D., Indianapolis

(3) Place of Cytoreductive and Second Look Surgery—John D. Tharp, M.D., Muncie; Neale A. Moosey, M.D., Indianapolis

(4) Methods of Node Dissection—Michael G. Hostetter, M.D.; William E. Chapman, M.D.; Joseph C. Butterworth, M.D., Indianapolis

3:55 p.m. Break

4:00 p.m. RENAL CELL CARCINOMA
Moderator—Michael Hoog, M.D., Fort Wayne
(1) What Is a Radical Nephrectomy?—George M. Haley, M.D., South Bend; David P. Schlueter, M.D., Fort Wayne; Charles J. Cooney, M.D., Fort Wayne
(2) Immunology Studies—Thomas Hakala, M.D., University of Pittsburgh, Pittsburgh; Bruce Romick, M.D., Indianapolis
(3) Survival Data—Willis Peelle, M.D.; Robert A. Garrett, M.D., Indianapolis



HOWARD R. MARVEL, M.D.
Lafayette

In practice with Section on Allergy and Immunology, Arnett Clinic, Lofayette; clinical associate, foculty of Indiona University School of Medicine, Lafayette Center at Purdue; board certified in internal medicine ond allergy ond immunology; M.D. degree from University of Michigan in 1948.

Section on Allergy and Immunology

(Possible Hours of Accreditation 2.5)
Entertainment Parlor

1:00 p.m. UPDATE ON MANAGEMENT OF BRONCHIAL ASTHMA FOR THE DOCTOR IN GENERAL MEDICAL AND FAMILY PRACTICE, Raymond G. Slavin, M.D., professor of internal medicine and microbiology, St. Louis University Medical School, St. Louis
Question-and-Answer Period

3:00 p.m. to 3:30 p.m. TREATMENT OF THE ACUTE ASTHMATIC EMERGENCY, Howard R. Marvel, M.D., Lafayette
Business Meeting—Election of 1977 Section Officers



RAYMOND G. SLAVIN, M.D.
St. Louis

Professor of internal medicine; director of Section of Allergy ond Immunology, St. Louis University Medicol School; consultant, St. Louis University Hospitol, Cardinol Glennon Hospital for Children ond Veterans Administrotion Hospital; Fellow, Americon College of Physicions and American Academy of Allergy; M.D. degree fram St. Louis University.

1:30 p.m. Final Meeting of the House of Delegates, Ballroom Centre, Lower Lobby

A financial contribution has been received from Blue Cross and Blue Shield of Indiana, Bristol Laboratories, Ciba Pharmaceutical Company, Immke Circle Leasing, Inc., Eli Lilly & Company, Mead Johnson Laboratories, The Medical Protective Company, Merck Sharp & Dohme, Parke, Davis & Company, A. H. Robins Company, The Upjohn Company and Wyeth Laboratories to assist with the educational program at the 1976 Convention.

Program—ISMA Auxiliary

President—Mrs. David A. Goldsmith, Marion
General Chairman of Women's Activities—Mrs. John G. Pantzer, Indianapolis
Committee Members—Mrs. Robert S. Carpenter, Lafayette; Mrs. Harold G. Halbook, Indianapolis; Mrs. Norman H. Liebschutz, Indianapolis; Mrs. James E. Schroeder, Indianapolis; Mrs. Thomas F. Trainer, Indianapolis; Mrs. H. Marshall Trusler, Indianapolis

Monday, Oct. 11, 1976

8:30 a.m. to 11:00 a.m. Hospitality Area and Message Center, Lower Level, Hilton Hotel

12:00 noon IMPAC Luncheon, Royal Center, Lower Lobby

2:00 p.m. General Meeting (open to spouses) Royal East, Lower Lobby

5:30 p.m. Reception for 50-Year Club, Festival East, Lower Lobby

7:00 p.m. President's Reception, Lower Lobby Corridor

7:45 p.m. President's Dinner, Royal East and Center, Lower Lobby

Tuesday, Oct. 12, 1976

"A DAY WITH YOU IN MIND"
at the Children's Museum, 30th and North Meridian (entrance on Illinois)

9:30 a.m. Open Board Meeting
11:30 a.m. Social Hour
12:00 noon Informal Luncheon
1:00 p.m. to 3:00 p.m. Program—Four Seminars

UPDATING YOUR FALL WARDROBE
Mrs. Janet Hoffman, fashion coordinator

HOW TO GET WHAT YOU ALWAYS WANTED OUT OF MARRIAGE BUT WERE AFRAID TO ASK
Dr. George A. Boyle, executive director of the Institute of Pastoral Counseling

NEW BEAUTY FOR YOU
By a specialist in cosmetics and make-up

TOUR OF THE MUSEUM—"There's Nothing Quite Like It"

Explore the twisting passageways of a limestone cave, step into the cold, dark tomb of an Egyptian mummy and examine an 1890s firehouse complete with a slippery fire pole—these adventures and more await you on your tour of the new Children's Museum, the largest of its kind in the world.

Reports of Officers

Executive Director

First of all, I want to let you know how delighted and flattered I was to have been selected to succeed Jim Waggener as your new executive director. I assure you I shall do everything I can to justify the confidence placed in me and look forward to a long and productive relationship.

As I indicated when first coming aboard in February 1976, I planned to undertake an objective review of the Association's overall operation, making recommendations where necessary for consideration by the Board of Trustees. Some administrative changes have already been implemented while still others will be recommended to the Board in the near future. For example, the number of sets of minutes produced of each Board meeting has been reduced from three to one in the interests of eliminating unnecessary duplication and reducing costs. A new headquarters telephone system will be installed shortly which will be more efficient in terms of our present needs and at the same time less costly than our existing system.

One of my most important and immediate goals is to improve and strengthen the channels of communications between ISMA and its component county societies and with other health related organizations as well. Effective communications with its members is the key to survival for any organization.

We did want to have an opportunity to become better acquainted with how things have operated in the past before formulating specific recommendations for the Board. However, I do want to share with you several general goals which I envision for the Association.

1. *Membership.* State medical societies can no longer afford to be complacent with regard to membership. There is a compelling need for the Association to identify and develop additional tangible benefits of membership in order to make membership more appealing. At the same time we must publicize the merits of our existing package of benefits. Accordingly, your ISMA has embarked on the formulation of an ongoing membership recruitment, retention and development program. The results of our first membership letter and supplementary dues notice (third billing) have been most gratifying. It enabled ISMA dues-paying membership to exceed that of 1975 as well as surpass our projected income budget. A detailed membership report will be included in a later issue of *The Journal*. Perhaps most significant is the fact that the membership letter brought back into the fold a number of physicians who had dropped their memberships back in 1974. An attractive brochure describing the benefits of ISMA membership will soon be available for distribution and will become part of the revamped information kit for new members.

2. *Income.* It is incumbent upon the Association to identify and develop new non-dues sources of income to supplement dues income. We simply cannot continue to raise dues indefinitely.

3. *Representation.* The Association must become the physician's advocate. Its continuing viability will be based upon its ability to vigorously champion the rights and position of practicing physicians against the constant encroachments of government into medical practice.

4. *Political.* There is a strong need for ISMA to become a more effective and potent political force. This can best be accomplished by strengthening the Association's political arm, IMPAC; and activity along this line is already underway. Physicians need to become more actively involved in politics, but if time is an obstacle then they should lend their financial support. In order for IMPAC to be effective in playing the game of practical politics, it must be unencumbered by party labels and cannot afford to be perceived as the captive of any one party. It must be free to support candidates who support medicine's position on the issues.

5. *Legislative.* The Association has been quite successful with its state legislative program. The ISMA achieved national acclaim for spearheading landmark legislation (P.L. 146) to cope with the medical liability crisis. However, there is a recognized need to strengthen ISMA's liaison with Indiana's congressional delegation. Such liaison must be ongoing rather than merely periodic. The opportunity is available for ISMA to have a greater input into the shaping of important national policies which, in most instances, have more far-reaching impact on the practice of medicine than state legislation. Steps in this direction have already been taken.

6. *Planning.* Anyone somewhat knowledgeable about medical care in this country has to wonder about the future of organized medicine and where it is headed! Consequently, a good deal of emphasis needs to be placed on planning. It's too easy to become so consumed in "fighting the alligators," so to speak, that one forgets that perhaps the most effective device for dealing with them is to drain the swamp. Medical associations can not afford to allow themselves to fall into this trap.

As busy practitioners you have a right to expect the appropriate long-range leadership from your state and county officers and your staff. It is the obligation of staff to facilitate intelligent decision-making and to assist in anticipating the future. If the practice of medicine as we know it today is going to survive in anything like its present form, your Association must remain vigilant and look ahead—perhaps five years ahead.

Your Future Planning Committee is attempting to do just that. In order to obtain base line data for evaluating members' needs and charting a course for the future direction of the Association, the Committee has developed a membership questionnaire. The Future Planning Committee has also developed a proposal for conducting a feasibility study concerning the Association's involvement in computer applications. It is the Committee's belief that ISMA should be the principal authority and agency in Indiana for the collection and dissemination of all physician-related data.

The Commission on Constitution and Bylaws will recommend to the House at the October 1976, meeting a new streamlined constitution patterned after that of the AMA. In the course of its revision efforts, the commission discovered much duplication of material between the present ISMA Constitution and Bylaws which leads to confusion and constant inconsistencies. This new approach would eliminate such duplications and incorporate the material currently contained in the Constitution into the Bylaws, thus simplifying understanding and readability.

This year there will be no commercial exhibits at the annual convention, thus enabling us to eliminate the necessity for renting the Indianapolis Convention Center. We will retain some scientific exhibits but they will all be accommodated in the headquarters hotel, as will be practically all the events associated with the convention. The commercial exhibitors have received this change of approach very well and many have pledged financial support for the scientific program in lieu of exhibiting. The elimination of commercial exhibits provides greater flexibility in the selection of future meeting sites.

Your executive director has felt extremely fortunate in having inherited a loyal and capable staff. This is an asset that can not be purchased but one that is critical to the success of any association. There is always room for improvements, however; consequently, current staff functions are being reviewed, which will undoubtedly result in certain realignments of responsibilities.

It is our intention to have the field service staff truly become the "eyes and ears" of the Association and a real extension of the headquarters office. They have been instructed to become even more involved in providing service to

county and district societies in addition to serving as important communication links.

The headquarters building has taken on a new manicured look with the recent employment of a full-time maintenance man. The previous commercial cleaning service has been terminated and we now have an individual available on a full-time basis to handle the routine daily cleaning, attend to backlogged maintenance projects, perform minor repairs and a variety of miscellaneous chores.

We are convinced that the single most important issue facing organized medicine today and for the immediate future is rising health care costs. According to the President's Council on Wage and Price Stability: (1) Health care costs are rising much more rapidly than the overall rate of inflation in the economy. (2) The rising cost of health care is impacting the disposable income of every American family. (3) Health care costs are expected to rise sharply for the foreseeable future. The Council has declared the rise in health care costs to be a major public policy problem for the nation.

Despite the fact that most of the increase in costs occurring during the past 10 years is explainable and should have been predictable, the proponents of a nationalized health care delivery system will use the rise in health care costs to demonstrate that the present system is out of control and, therefore, further regulation and cost containment mechanisms must be imposed. One way physicians might come to grips with this issue is by developing a cost conscious approach; that is, becoming better acquainted with the cost of the procedures ordered for patients and looking at the cost-benefit ratio. Of course, less costly decisions are more likely to be made in an atmosphere where the threat of malpractice is better contained.

The American Medical Association is concerned, along with everyone else, over mounting costs and, in recognition of this problem, recently formed a Commission on the Cost of Medical Care. This is a diverse group that includes representation from management, labor, consumers, health professionals, the insurance industry and Congress. The Commission will study the problem of rising costs and recommend private sector actions to hold down increases in medical care costs, hopefully, without jeopardizing quality.

Your medical profession is entering perhaps its most critical period and will be faced with many formidable challenges in the years immediately ahead. The pressures from government for tighter regulation and control of medical practice continue to mount. If the medical profession is to meet these challenges, there is a critical need for strong, aggressive and vigilant leadership, as exemplified by medicine's very first lawsuit against government regulations—specifically, HEW's utilization review regulations. Organized medicine needs the active support of every practicing physician if it is to continue its fight against further government encroachments into medical practice, ensure the passage of sound legislation and defeat that which is irresponsible.

DONALD F. FOY
Executive Director

Actions and Disposition of Resolutions, 1975 House of Delegates

In accordance with the directive of the House of Delegates and the Constitution and Bylaws, your executive director lists herewith the disposition of actions taken by the 1975 meetings of the House of Delegates, Indiana State Medical Association.

RESOLUTION 75-1, CREATION OF A SECTION ON ORTHOPEDIC SURGERY

Action: Adopted. Referred to Commission on Constitution and Bylaws with the recommendation that a study of the question of creation of new sections be instituted.

Status: The Commission on Constitution and Bylaws has studied this matter during the past year and has included, in the revised format of the Constitution and Bylaws, procedures for creating new sections of the ISMA.

RESOLUTION 75-4, LOCATION OF AMA MEETINGS

Action: Adopted with the recommendation that AMA delegates introduce this resolution at the next AMA meeting.

Status: The resolution resolved that "until such time as the Association's resources permit the luxury of travel and transportation of staff and equipment, all meetings be held in Chicago, except for government-related activities which may be better served by a Washington location; and that scheduled sessions at distant sites be rescheduled for Chicago unless compelling and persuasive reasons can be advanced with appropriate fiscal data."

The AMA delegation introduced this resolution at the 29th Clinical Convention in December 1975. The resolution was not adopted. The AMA Reference Committee to which the resolution was referred recommended that "inasmuch as all interim meetings of the House of Delegates will be held in Chicago after 1977 and the present Board of Trustees' policy encourages all councils and committees to meet in Chicago, the intent of this resolution appears to be satisfied."

RESOLUTION 75-5, ISMA MEMBERS' INSURANCE PLAN

Action: Adopted with the resolve that the Indiana State Medical Association through its Commission on Medical Economics and Insurance shall further study the matter of an insurance program for all its members which would permit its members to purchase all types of insurance through a self-insurance program of the Indiana State Medical Association.

Status: A program which would permit ISMA members to purchase all types of insurance through a self-insurance medium is now being explored by the Future Planning Committee of ISMA.

RESOLUTION 75-7, TEL-MED

Action: Adopted as amended and referred to the Board of Trustees to determine the feasibility of funding and continuance of Tel-Med and directed that the Board ask for voluntary contributions.

Status: The president of the Association, in a personal letter to all United Ways in Indiana, solicited funds for Tel-Med and was successful, in a limited way, in getting contributions. Additionally the Board of Trustees supported the idea of imprinting upon the dues notices to members a request for a $25 voluntary contribution for Tel-Med. The total amount received from 1,243 members, as of July 31, 1976, was $30,765.

RESOLUTION 75-8, MEDICAL MUSEUM

Action: Adopted as amended. Referred to the Board of Trustees.

Status: The House asked that the Board of Trustees investigate voluntary contributions for this endeavor. The Board of Trustees authorized imprinting upon the dues notice a request for a $2.50 voluntary contribution. This total as of July 31, 1976, was $3,668.05, with 1,480 members contributing.

RESOLUTION 75-9, FEE INEQUALITY

Action: Substitute Resolution 75-9 was adopted with the resolve "that ISMA and its Board work for elimination of different fee schedules based on geographical regions and that the manner in which this is accomplished be to the benefit of both the physician and the patient."

Status: The Board continued study of this matter; there were no specific actions taken.

RESOLUTION 75-14, AMA POLICIES ON MEDICAL INFORMATION TO THE LAY PRESS

Action: Adopted with the recommenda-

tion that the AMA Delegates refer this resolution to the AMA. The resolution stated "that the Indiana State Medical Association seek from the American Medical Association adoption of a publication policy which requires advance distribution of information to physicians which may be applied by members of the public without consultation of their physician or may imply inadequacy of treatment delivered in accord with convention."

Status: The AMA Delegation introduced a resolution dealing with this subject at the AMA annual convention in Dallas. The resolution was rejected by the AMA House.

RESOLUTION 75-17, MEDICAL EXAMINER

Action: Adopted as amended. The resolution: "Whereas, in many instances law officials experience difficulty in determining a cause of death; therefore, be it resolved, that the Association cause to be introduced in the 1976 General Assembly a bill to create a medical examiner system in the state of Indiana."

Status: An effort was made to introduce the bill in the 1976 General Assembly but these efforts were unsuccessful. A new bill is currently being formulated by the legal counsel of the ISMA and plans are being made for introduction in the 1977 General Assembly.

RESOLUTION 75-35, VALID PATIENT-PLAINTIFF CLAIMS UNDER H.B. 1460

Action: Referred to the Board of Trustees to send to Indiana State Study Committee. The resolution read in part, "Whereas, patient-plaintiffs with obviously valid claims are not well served by the requirements that they elect to pay the attorney on a per diem or contingency fee basis at the time of employment; therefore, be it resolved that ISMA Board of Trustees seek to introduce legislation to postpone such a determination until after the Medical Review Panel has met, reviewed available information, and indicated if there is an obviously valid claim."

Status: The matter was referred to the Indiana State Study Committee.

RESOLUTION 75-37, CLAIMS-MADE TYPE OF PROFESSIONAL LIABILITY INSURANCE

Action: Adopted as amended. The resolve read, "Resolved, that the Indiana State Medical Association continue to investigate all forms of acceptable professional liability insurance in order to satisfy the individual needs of each practicing physician."

Status: The ISMA has continued through the year to investigate all forms of insurance. The Board of Trustees heard a detailed report on claims-made type insurance from an insurance company representative and passed a motion to the effect that utilization of claims-made policies in Indiana be at the discretion of the insurance commissioner.

Chairman of the Board

The first meeting of the Board of Trustees, following the organizational meeting and election of officers which was held at the conclusion of the final meeting of the House of Delegates in October, was held on Nov. 16, 1975. Each meeting of the Board was characterized by a large number of items on the agenda to be considered.

The Board concerned itself greatly with the ongoing problem of professional liability insurance and assisted in the formulation and circulation of a questionnaire to obtain current data on the professional liability situation in Indiana. The request had come from the Governor's Study Commission on Liability Insurance.

In February the Board increased the mileage allowance from 10¢ to 15¢ per mile for all ISMA committee members attending meetings and official functions of the Association. The Board also increased, for one meeting only, the allowance for AMA delegates and alternates who would be attending the AMA convention in Hawaii.

In discussions of the 29th Clinical Convention of the American Medical Association the Board directed the AMA delegates to vote against national health insurance (described as government-sponsored, all-paid). The Board also directed the delegation to oppose a resolution which would have made the $60 assessment of members mandatory.

The Board also met with the AMA delegation prior to the AMA Annual Convention in Dallas and reviewed a multitude of reports and resolutions to be brought before the AMA House. Results of actions are contained in the report of the Delegates.

During the year, through action of the Board and submission of an application to the American Medical Association, the ISMA received a $25,000 grant to participate in a Jail Medical Care Project in conjunction with six other states. The purpose of the three-year project is to develop standards for certification in jails. Dr. Dwight Schuster is project leader in Indiana.

The Board also took action to incorporate in the dues billings to members a request for a $25 contribution for the Tel-Med program and also a request for a $2.50 contribution to the Indiana Medical Museum.

In December the Board employed Mr. Donald Foy as executive director of the Association. He officially took over his responsibilities on Feb. 1, 1976.

One of the many items discussed by the Board was the problem of health insurance carriers not paying for specific services to patients in doctors' offices while at the same time paying for these same services in a hospital. A Board committee was directed to look into this matter and seek solutions.

Dr. Lowell H. Steen, a trustee of the AMA, kept the Board posted on current activities of that Board, and district trustees of the Association also reported activities from their districts. Supported by the Board and the AMA delegation, Dr. Steen was successful in his bid for reelection as AMA trustee.

Certificate of need legislation was discussed periodically. The Board adopted a motion which stated that the ISMA opposes the current certificate of need legislation unless the physician is completely exempted from the act.

PSRO was a continuing matter of concern to the Board and the concept of a statewide PSRO as opposed to regionalized PSRO. It was moved by the Board that, if the inevitability of a PSRO were a fact, the ISMA favor a statewide PSRO over the regionalized concept.

The Board undertook a study of alternative proposals to the members' health insurance coverage currently provided by Blue Cross and Blue Shield and it was pointed out that ISMA members should be encouraged to select a major medical plan as opposed to the first-dollar coverage type of health care coverage.

Antisubstitution legislation was discussed, with the Board reaffirming its policy against generic substitution of prescribed drugs.

Changing the format of the ISMA Annual Convention also came before the Trustees who endorsed eliminating from the annual convention, for the first time, commercial exhibits. Scientific exhibits, however, it was decided, should be continued. In the discussion as to charging a registration fee to members who attended the Convention, the Board resolved negatively on this issue.

Confusion on the problem of "remission of dues" came before the Trustees. The terminology has been used throughout the years as applicable to retired, disabled or hardship status. The staff was directed to prepare a form based on definitions which would explain fully the categories of membership and dues status, so that when a change in status is requested, the county medical society could fill out the questionnaire which would be self-explanatory and simplified.

Concerning Health Service Areas, the Board moved that information concerning major events and changes which affect the medical aspects of membership in HSA be sent to trustees, alternate trustees and presidents of county medi-

cal societies by the executive directors of the HSA areas.

The Board learned that an accelerated program to increase membership in IMPAC would be undertaken. Current membership is 1,808. Additionally, IMPAC, in an effort to exchange information on health issues and candidates, has instituted meetings with representatives from the Indiana Hospital Association, Indiana Nursing Home Association, Eli Lilly and Company, Dow Chemical Corporation, the Chamber of Commerce, the National Association of Manufacturers and others.

The Future Planning Committee reported to the Board that plans are being made for conducting a membership opinion poll to solicit comments on the types of services members would like to have the Association provide. The Committee also reported that plans are in the development stage to conduct a feasibility study regarding computer applications. The concept, protocol and estimates for the study were to be presented to the Board at its August meeting.

Although the matter was taken for information only, it was suggested to the Board that the ISMA consider employing an individual or individuals to assist physicians and county medical societies in keeping informed on the broad spectrum of activities and actions of the three Indiana Health Service Area organizations.

This report does not explain all of the actions, considerations and deliberations

INDIANA STATE MEDICAL ASSOCIATION
Statement of Financial Condition

ASSETS

	5/31/76	9/30/75
GENERAL FUND:		
Cash on deposit	$ 92,145	$ 80,279
Investments—at cost:		
U.S. Treasury Bonds—long term	35,103	55,103
U.S. Treasury Bills—short-term	709,398	254,402
Accounts receivable	32,412	49,160
Prepaid expense and miscellaneous assets	10,374	20,015
Office furniture and equipment—net of accumulated depreciation	27,731	22,982
	907,163	481,941
BUILDING FUND:		
Cash on deposit	4,880	3,769
Cash in savings account	7,930	7,726
U.S. Treasury Bills	253,212	237,656
Prepaid expense	1,833	567
Accounts receivable	344	
Headquarters property		
Land	69,188	69,188
Office building and improvements—net of accumulated depreciation	231,379	234,218
Rental properties—net of accumulated depreciation	76,153	75,008
	644,919	628,132
STUDENT LOAN:		
Cash in savings account	19,190	19,190
Certificates of deposit	20,810	20,810
	40,000	40,000
MEDICAL DEFENSE FUND:		
Accounts receivable	1,105	
Cash in savings account	34,962	31,167
U.S. Treasury Bonds—long term	25,069	25,306
	61,136	56,473
	$1,653,218	$1,206,546

LIABILITIES AND FUND BALANCES

	5/31/76	9/30/75
GENERAL FUND:		
Accounts payable	$ 23,376	$ 20,164
Accrued taxes		25
Dues payable to AMERF	20,433	20,910
Advances from AMA	9,278	9,278
Unearned portion of current year dues	433,602	131,163
Deferred Tel-Med contributions	29,063	
Contributions annual meeting—deposits	1,000	7,200
Lease contracts payable	845	1,091
Fund balance	389,566	292,110
	907,163	481,941
BUILDING FUND:		
Accrued taxes on rental properties	1,250	1,508
Damage deposits and accounts payable	495	1,831
Loans from members (non-interest bearing)	19,575	19,875
Fund balance	623,599	604,918
	644,919	628,132
STUDENT LOAN:		
Fund balance	40,000	40,000
	40,000	40,000
MEDICAL DEFENSE FUND:		
Fund balance	61,136	58,473
	61,136	56,473
	$1,653,218	$1,206,546

of the Board which transpired during the past year, but it is intended to give membership and the House of Delegates a concept of the types of problems with which the Board must deal during its sessions.

Your Association has a Board which carries out its responsibilities conscientiously and much thoughtful discussion prevails before decisions are made.

I wish to thank the trustees for their assistance during the year.

ELI GOODMAN, M.D.
Chairman

Treasurer

In previous years we have published an abbreviated report in the September issue and carried the complete audit in the January issue of *The Journal*. The reason for this was that the audit is not made until after the close of our fiscal year (Sept. 30) and is never available in time to submit to the House of Delegates.

As was done last year, I am presenting an unaudited report of the financial condition as of May 31, 1976, and the figures from the Sept. 30, 1975 audit, for comparison. I hope in this way it will give our members a more current review of the financial conditions of the State Association.

ARVINE G. POPPLEWELL, M.D.
Treasurer

First Trustee District



BERNARD B. ROSENBLATT, M.D.
Trustee

The First District Medical Society held its annual meeting on May 13, 1976, at the Evansville Country Club. Pre-meeting festivities included the First Annual Robert Acre, M.D., Golf Tournament, named in honor of the only physician ever to win the All-City Golf Tournament. Mrs. Acre, widow of the late Dr. Acre, made a special contribution which permitted golf balls to be provided tournament participants at no charge. Winners were Wallace M. Adye, M.D., low net, and William D. Ritchie, M.D., low gross.

Martin J. Bender, M.D., First District president, presided over the meeting. Dr. Bender called attention to the fact that medical executives from county medical societies throughout the state and from the ISMA office in Indianapolis were present at the meeting and would be attending an all-day session on May 14 to discuss common concerns. Those in attendance included, Don Foy, ISMA, Barbara Schilling, Marion County Medical Society, Hal Hefner, Marion County Medical Society, Kenneth Bush, ISMA, John Twyman, Lake County Medical Society, Larry Pickering, Allen County Medical Society, Robert Amick, ISMA, and Bob Sullivan, ISMA. Other guests included Eli Goodman, M.D., chairman of the Board of Trustees of the Indiana State Medical Association, and Mr. Herbert P. Dixon, vice-president, Provider Relations, Indiana Blue Cross-Blue Shield.

Speaker for the evening was Joseph Robert, Ph.D., author, lecturer, and past-president of two colleges in the state of Virginia. Dr. Robert spoke on a bicentennial theme, "The Physician and the Bicentennial: 200 Years of What?"

Several significant actions were taken during the business meeting. One of the most important actions taken was to incorporate the First Trustee District Medical Society. Thereafter, funds were transferred from the old unincorporated association, and by-laws were adopted.

The officers of the new association who were elected include Herman F. Rusche, M.D., president; James A. Marvel, M.D., vice-president; and Forrest F. Radcliff, M.D., secretary-treasurer. E. DeVerre Gourieux, M.D., was re-elected alternate trustee. Ralph F. Carlson, M.D., was reelected to a three-year term on the Indiana Blue Shield Board of Trustees.

Those present heard a report from Dr. Carlson. He mentioned the need for cost control in health care, pointing out that 10% to 20% of family income in 1975 went for health care expenditures; 20 years ago, family health care expenditures were half that amount. Dr. Carlson also noted that all Blue Shield plans received subpoenas to answer charges that they were acting in restraint of trade because they were excessively controlled by physicians.

Dr. Rosenblatt reported as First District trustee and made a special plea for members of the Society to let him know those areas in which they feel ISMA should be active. He remarked that he cannot be responsive to the real needs of the membership unless he is made aware of them, and he invited suggestions from the membership at any time.

BERNARD B. ROSENBLATT, M.D.,
Trustee

Second Trustee District



PAUL W. HOLTZMAN, M.D.
Trustee

The second district has returned to our "pre-malpractice law" existence of "let the boys who are interested in medical politics handle it." National health insurance, which could be a problem, has been quiet because of an inability of the government to fund the program. When our state delegation visited Washington, little interest in new laws regarding health legislation was encountered and the general attitude seemed to be "when Congress gets the money, they will bury you." Congress has that capability now with existing laws.

PSROs, HMOs and HSAs have been kicked around and are still a real threat. AMA attitudes have been criticized—usually by the poorly informed.

We, as physicians, are presently not being threatened financially and are accordingly—like ostriches—burying our heads in the sand.

PAUL W. HOLTZMAN, M.D.,
Trustee

Third Trustee District



ELI GOODMAN, M.D.
Trustee

The Third District, during the course of this year, held a meeting in conjunction with the Indiana State Medical Association Auxiliary at the Marriott Inn in Clarksville on Apr. 20 and 21, with a short business meeting at 3 p.m. on April 21. This was thoroughly enjoyed by all.

The regular annual meeting is scheduled at French Lick Sheraton Hotel on Sept. 11 and 12. The program will begin on Saturday afternoon with an update on the Use of Antibiotics and Use of Laboratories. Dinner will be served Saturday evening and there will be a brunch Sunday morning followed by a discussion of Parenting Problems in the Vulnerable Child, by Morris Green, M.D., Indianapolis.

The business meeting of the ISMA District will be at 4:30 p.m. on Saturday, Sept. 11. It will be necessary at this meeting to elect a District Trustee. The business meeting of the Academy of Family Practice, with whom this will be a joint meeting, will be at 5 p.m. on Saturday.

During the past year your Trustee has been serving as chairman of the Board of Trustees and has been deeply involved with the many problems facing organized medicine today. I have done my best to continue to represent our District involvement in professional liability insurance, PSRO, utilization review, reimbursement and these and many other

items have kept your Trustee a rather busy individual during the past year.

As I will not be eligible for reelection, having completed two terms of service to you, I wish once more to express my gratitude for your confidence in me and allowing me to represent you as your trustee for the past six years.

ELI GOODMAN, M.D.,
Trustee

Fourth Trustee District



HOWARD C. JACKSON, M.D.
Trustee

The annual meeting of the Fourth District Medical Society was held at the Greensburg Country Club in Greensburg on May 5, 1976. The business meeting was at 4 p.m. and Dr. Ivan Lindgren of Aurora was elected president; Dr. Larry Williams of Madison was elected vice-president and Dr. Gerald Bowen of Lawrenceburg was elected secretary-treasurer. Dr. William Blaisdell, alternate trustee, announced that he would not seek to succeed himself and Dr. Mark Bevers of Seymour was nominated for alternate trustee and subsequently elected. We welcome Dr. Bevers. Mr. Donald F. Foy, executive director, ISMA, spoke at our meeting of the benefits occurring to physicians by virture of their membership in the AMA and ISMA. We all hope that those benefits will increase in the coming years and we know that they would if we all become interested and participate in our societies and associations. Dr. Vincent J. Santare, president; Dr. John W. Beeler, president-elect and Dr. Eli Goodman, chairman of the Board of Trustees, also were present and took part in our meeting.

The trustees have debated and evaluated several ventures of the ISMA, some successful and some not so successful, during the past year. The Medical Liability Act, the Medical Practice Act, Tel-Med and the Indiana Medical Museum are some of our successes. I ask everyone by your voluntary contributions to support Tel-Med and the Indiana Medical Museum.

I alert you to possible drastic, divisive and detrimental changes to come in Blue Cross-Blue Shield. Government interference in medicine has been our major concern for the past 10 years and we have continually lost ground to its invasion. The past year has seen the Federal Trade Commission playing against out advertising policy, the publication by the House of Representatives of their evaluation of unnecessary surgery and the designation and activity of the Health Systems Agencies. Even in the fraternity of medicine, we find the pharmacists asking for repeal of antisubstance laws. We need, and I ask everyone, to become united in our deliberations and actions. We need, and I ask everyone, to trust and cooperate with one another.

HOWARD JACKSON, M.D.,
Trustee

Fifth Trustee District



CLEON M. SCHAUWECKER, M.D.
Trustee

On May 28th, members of the Fifth District and their wives met at the Elks Club at Brazil. Among the guests present were Dr. Eli Goodman, Dr. Peter Petrich, Mr. Foy, Mr. Dixon, and Mr. Amick. At the business meeting, Dr. Bill Bannon was reelected alternate trustee; Dr. Wm. Strecker, who was appointed to fill the unexpired term of Dr. Johnson as our representative on the Blue Shield Board of Trustees, was elected to that post. The officers for the coming year are: Dr. Fred Dettloff, president, Dr. Greg Larkin, secretary-treasurer—both from Greencastle. The meeting next year will be at Greencastle—time and place not yet set.

The main speaker of the evening was Representative John Meyers, whose main topic concerned the difficulties of getting proper legislation passed, and the woes of the Congressman. A lively question-and-answer period followed the presentation.

The best joke of the evening was overheard during the Happy Hour—and was attributed to Bob Hope—who was supposed to have stated that he could see no reason for the excitement being produced by the antics of Representative Hayes and Ms. Ray, because after all, she was only doing to congressmen what congressmen have been doing to the American public for years and years.

CLEON M. SCHAUWECKER, M.D.,
Trustee

Sixth Trustee District



PAUL M. INLOW, M.D.
Trustee

I will be concluding my term of office as trustee from the Sixth District at this annual meeting of ISMA. It has been an honor to serve the physicians of the Sixth District and I have enjoyed the friendships made at the state level. Glen Ward Lee, M.D., from Richmond, will be the new trustee from the Sixth District with Davis W. Ellis, M.D., Rushville, as alternate trustee.

The Sixth District Medical Society met at Westwood Country Club, New Castle, on May 12, 1976. Our speakers were H. Pete Hudson, insurance commissioner of the state of Indiana, who spoke on our new malpractice legislation, and Donald Foy, Executive Director of the State Medical Association, who talked to us about present and future services to the membership. The dinner speaker was Richard Lugar of Indianapolis, candidate for the U. S. Senate. C. G. Clarkson of Richmond was elected president of the Sixth District with O. L. Webb elected vice-president. Hancock County will designate the secretary-treasurer.

I plan to continue to serve Indiana State medicine by participation at the Commission level. We have taken a giant step forward in our attempt to solve the malpractice insurance problem in Indiana but we are far from a total solution. I am again personally involved in an attempt to find insurance in the open marketplace because of withdrawal of the company which previously wrote my malpractice insurance. This may involve paying two and one-half to three times the dollar amount for the same coverage which I enjoyed this past year. I hope that my fellow physicians are spared this nervewracking experience, but if they are so involved, urge them to report their experiences to the Study Commission of the Indiana State Legislature.

P. M. INLOW, M.D.,
Trustee

Seventh Trustee District



JOHN O. BUTLER, M.D.
Trustee



JOHN G. PANTZER, M.D.
Trustee

The annual meeting of the Seventh District Medical Society was held at the Hillview Country Club in Franklin on

June 9, 1976. The beautiful spring weather provided a perfect afternoon for 20 golfers. The day was also ideal for several of the ladies who enjoyed a card and pool party at the home of Dr. and Mrs. John Records.

Dr. John Records, Seventh District president for 1975-76, presided over the election in which Dr. William Stafford of Plainfield was selected president-elect and Dr. Malcolm Scamahorn of Pittsboro was elected to succeed himself as secretary/treasurer.

We were honored to have Governor and Mrs. Otis R. Bowen, M.D. as our guests. Following dinner, Governor Bowen spoke of state regulations and the need for regulation to be based on reasonable laws. Speaking of his administration, Dr. Bowen said, "Our goal has been one of building the level of the quality of regulated services to the public, primarily through the voluntary positive efforts of the industry where that can be done, and by punitive legal action where we must."

Continuing his theme, Dr. Bowen reported on his participation as the only gubernatorial member of the President's Commission on Federal Paperwork and posed the question "Why work to streamline forms and cut down hassle if there is no valid need for the information at all?"

The society was pleased to have among its guests Dr. Vincent Santare, ISMA president; Dr Eli Goodman, chairman of the ISMA Board of Trustees; Mr. James Waggener ISMA executive secretary emeritus, and his wife Norma; Mr. Donald Foy, ISMA executive director; and Mr. Bob Amick, ISMA field representative.

The meeting provided an excellent opportunity for the recognition of Mr. Waggener by the Johnson County Medical Society. Mr. Waggener, whose distinguised career began in Franklin, served 27 seven years as ISMA executive secretary through Feb. 1, 1976. An engraved plaque and a silver compote were presented to Mr. and Mrs. Waggener to mark Jim's election to honorary membership in the Johnson County Medical Society.

A solemn moment of silent prayer was offered in memory of our good friends, Dr. Fred Toumey and Dr. Malcolm Wrege, members of the Marion County delegation who had recently been taken from our midst. Their devoted service to medicine and its organizations will not soon be forgotten.

JOHN O. BUTLER, M.D.
JOHN G. PANTZER, M.D.
Trustees

Eighth Trustee District



JACK M. WALKER, M.D.
Trustee

There has been very little of an unusual nature occurring in the Eighth District of the ISMA.

The Eighth District annual medical meeting was hosted by the Madison County Medical Society and was held at the Anderson Country Club on June 2, 1976. The meeting was very well attended, and the dinner meeting was addressed by senatorial candidate Richard Lugar.

At the business meeting Dr. Donald R. Taylor was reelected to his position on the Blue Shield Board, Dr. Ted Doles was elected alternate trustee from the Eighth District, Dr. Clarence Ashburn was elected president of the Eighth District Medical Society, and Dr. David Dietz was elected secretary-treasurer of the Eighth District Medical Society.

The meeting in 1977 will be hosted by the Delaware County Medical Society.

JACK M. WALKER, M.D.
Trustee

Ninth Trustee District



WILLIAM M. SHOLTY, M.D.
Trustee

Thinking back over six years as ISMA Ninth District Trustee I am aware that many outstanding things have been accomplished; important decisions have been made and there are also many problems arising. The vicious, ugly movement toward Marxist medicine is frequently the main underlying cause of most of the problems facing medicine today. Your ISMA is dedicated to do all possible to maintain and preserve the free practice of quality medicine. One gets a sense of gratification from having participated in the sincere effort of finding solutions to the problems that have arisen. We hope and pray they been correct.

I would like to urge all ISMA members to actively participate in their local county, state and national organizations. Become informed. Find out what is going on. Let your opinions be known and fight the constant pressure from the left. The ISMA is a fine, powerful organization that can and will help you.

The Ninth District is composed of 12 counties strung out from Lake to Vermillion County and from the Illinois state line to Madison County. Distance and physician population are a problem. This year Tippecanoe County hosted the district meeting for Tipton County. The golf meet was held at the Purdue South Course, the meeting and dinner were held at the Hilton Inn on June 3. Dr. John Knote conducted the meeting. Introduction and remarks of guests included Dr. Vincent J. Santare, president, ISMA: Dr. John W. Beeler, president-elect; Dr. Eli Goodman, chairman of the Board, Dr. James A. Harshman, Eleventh District trustee; Mr. Donald F. Foy, executive director, ISMA and Mr. Herb Dixon, professional relations, Blue Shield.

The subject of Tel-Med was brought up by the Trustee. A resolution was made, seconded and passed that the House of Delegates increase the ISMA dues an appropriate amount to finance the Tel-Med program and that this money be designated solely to finance the Tel-Med program.

Another motion was made, seconded and passed that the Ninth District call for a more explicit definition and specific functions of the Medical Audit Review Committee. A number of problems have developed in this regard.

Dr. Peter R. Petrich, Ninth District Blue Shield representative, reported that Blue Shield's losses this year will be less than expected.

A number of committee and commission reports were given by Drs. Kenneth Ahler, William Ferguson, Peter R. Petrich, Lindley Wagner, John Knote and Paul Honan.

Dr. John Knote was elected Ninth District trustee to succeed Dr. William M. Sholty. Doctor Petrich was reelected Ninth District Blue Shield Board member. Dr. Max Hoffman will continue as alternate trustee.

The dinner was well attended and the program was given by Professor Hans Adolph Heinrich of the Public Relations Department of Argonne Laboratories in Chicago.

I would like to state that I consider it an honor and privilege to have had the opportunity to serve the medical profession as Ninth District Trustee and I am sure that the doctors will extend the same cooperation to the new trustee.

WILLIAM M. SHOLTY, M.D.
Trustee

Tenth Trustee District



MARTIN O'NEILL, M.D.
Trustee

The last annual meeting of the Tenth Trustee District was held Sept. 24, 1975, at Valparaiso Country Club. Dr. J. M. Siekierski, president, presided and introduced the officers present. In the election that followed these officers were reelected for another term. They were Dr. Siekierski, president; Dr. James R. Brown, secretary-treasurer; Dr. Leonard W. Neal, alternate trustee, and Dr. William J. Fitzpatrick, representative to Blue Shield Board. Trustee Martin J. O'Neill was also introduced and spoke briefly concerning the Indiana malpractice act and urged members to attend the annual ISMA meeting in October at French Lick. The president of the Lake County Medical Society, Dr. Walfred Nelson, and Dr. Leon Armalavage, president, Porter County Medical Society, were introduced, along with Dr. Thomas C. Tyrrell, alternate AMA delegate; Dr. Lee Trachtenberg, president Calumet Area Foundation for Medical Care; Mr. John Twyman, executive director, Lake County Medical Society; Mr. Charles Shoemaker, executive director, Calumet Area Foundation for Medical Care, and Mr. Howard Grindstaff, field secretary of ISMA. There were several guests present at the business meeting, including Dr. Ernest R. Beaver, president, Indiana Medical Licensing Board; Dr. William M. Sholty, Ninth District trustee; Dr. Peter R. Petrich, alternate AMA delegate and past president of ISMA, and Messrs. Gary Miller, Phil Sizelove and Bill Kelly of Indiana Blue Shield.

Area members of the Indiana General Assembly were invited to this meeting and those present included Representative Phillip Bainbridge, Speaker of the House of Representatives, and Mrs. Bainbridge (who incidentally won the door prize—a Polaroid camera); Representative and Mrs. Chester Dobis; Representative and Mrs. Jewell Harris; Representative and Mrs. Jerry Reppa; Representative and Mrs. Walter Roorda; Senator and Mrs. Ralph Potesta and Senator and Mrs. William Christy. Representative Bainbridge discussed the malpractice law and the Medical Practice Act during the business meeting.

Dr. Vincent Santare, president-elect of ISMA, was introduced and discussed a number of matters coming before the House of Delegates at the French Lick meeting.

Dr. Lowell Steen, newly elected to the Board of Trustees of the AMA, was introduced and spoke of the new militant stance of the AMA with regard to federal interference through regulation of the medical profession.

There was a golf tournament with prizes awarded to Dr. Joel Hull, low gross, Dr. Kumpoz Dennison, low net, and Dr. Paul Alvarez, closest to the pin.

Mrs. Vincent J. Santare presided over the ladies' program in the afternoon and there was entertainment following the dinner.

It was a good meeting, with 110 people in attendance. The next annual meeting will be Sept. 8, 1976, at Woodmar Country Club, Hammond and we hope to have a larger attendance.

New county society officers were elected during the year. Dr. Lambro Dimitroff was chosen president of Lake County Medical Society and Dr. David E. Ross, secretary. Porter County Medical Society elected Dr. Frederick D. Hoham president, and Dr. James R. Brown secretary. Both socieites, along with the Calumet Area Foundation for Medical Care, have been active in the areas of CHP, HSA, HMO-IPA, and PSRO. The Calumet Foundation was denied a grant for an HMO feasibility study and later discussed the advisability of submitting an application for a planning grant for a HMO-IPA. This may de done at the opportune time. At the present, we have been informed that there is no money available from HEW for this purpose.

An in-depth hospital utilization study is being done by the Coordinated Care Program Committee (CCP) of Calumet Area Foundation for Medical Care. This committee was formed as a result of a contract with Inland Steel to do such a study, and most Lake County hospitals are involved in the project with physician-advisor subcommittees in each hospital. The cost of the study is borne by Inland Steel and the data gathered is, primarly, for information only.

The physicians in the Tenth District are very proud to have two outstanding medical leaders in their membership; namely, Dr. Vincent Santare, president of ISMA, and Dr. Lowell Steen, past president of ISMA, who was recently reelected to the AMA Board of Trustees. Both of these doctors are exceptionally well informed, articulate, and, apparently, have boundless energy, judging from the hours they spend performing the tasks they have undertaken. We express our thanks to them and look forward to their continued leadership in the troublesome time ahead.

MARTIN J. O'NEILL, M.D.
Trustee

Eleventh Trustee District



JAMES A. HARSHMAN, M.D.
Trustee

Since last October, much of organized medicine's energies have been diverted to the courtroom. A challenge to the constitutionality of our new law on professional liability insurance has been filed in a Marion County court. On the national scene utilization regulations are still in the news. As of the writing (July 15) final regulations have not been published. If they are similar to those published in the preliminary filing, the AMA will probably reinstitute its suit against HEW.

Several states and the AMA have challenged the constitutionality of P.L. 93-641, the National Health Planning and Resources Development Act of 1974. The Federal Trade Commission has filed two charges against the AMA, and both will probably be heard this year. One charge against the AMA is that its Code of Ethics prohibiting advertising is in restraint of trade. The FTC has not achieved truth in advertising for products. It is almost inconceivable to think they could achieve truth in advertising for something as intangible as a professional service. The other FTC charge against the AMA asserts that the AMA controls the number of physicians by limiting admissions to medical schools through its accreditation program and thus violates restraint of trade laws.

National Health Insurance may be one of the major bills debated in the next Congress, depending on the next occupant of the White House. One political party has already indicated that the enactment of NHI will be one of its early high priority bills in the next congress.

There is no question that the physicians in the 11th District, and in the rest of the country for that matter, have as their major concern today the interference of big government between their patients and themselves. This interference is growing daily by leaps and bounds.

Both the ISMA and the AMA have recently reorganized their committee and council structures. Hopefully they can react to the needs of our members in a rapid and effective manner. The tasks they face are of great magnitude and of great importance. Our future may be determined in the next year.

Last September, Carroll County was the host for the 11th District Medical Society in Delphi. The meeting was well attended. Dean Andrews of Purdue University was guest speaker for the evening. Dr. Richard G. Blair of Huntington was elected president, and Dr. Fred Poehler of LaFountaine was reelected secretary of the District Society. Dr. James A. Harshman of Kokomo was reelected trustee. The next District meeting will be held on Sept. 15, 1976, in Huntington and the Huntington County Medical Society will be host.

JAMES A. HARSHMAN, M.D.
Trustee

Twelfth Trustee District



ALVIN J. HALEY, M.D.
Trustee

The 12th District Medical Society will meet Sept. 9. 1976, at the Fort Wayne Ramada Inn. Featured speaker is Governor Otis Bowen. The women's program concerns (for the Bicentennial year) frontier homemaking, arts and crafts.

The 12th district officers this year were: president: Robert J. Edwards, M.D.; vice president: Karl Schlandemann, M.D.; secretary-treasurer: Tom Felger, M.D.; trustee: Alvin J. Haley, M.D.; alternate trustee: Franklin A. Bryan, M.D.; Blue Shield Board: Harry Tunnell, M.D.

The above officers met three times during the past year to plan for the annual meeting and attend to regular business. I would like to see these officers meet on a regularly scheduled basis, perhaps with the delegates attending. I feel this extra effort is necessary to improve communications, plan for our district's position at the annual ISMA meeting and make the trustee's position truly representative.

The board of trustees meets regularly every two months with special meetings added. Last year's major business was malpractice legislation; this year's most important business appointing Mr. Donald Foy executive director of the ISMA, a much happier involvement! Mr. Foy is assuming his duties very capably. I am sure he will become a mainstay to the ISMA.

Another shining moment was the election of Lowell Steen, M.D., to trustee of the AMA. Our AMA delegation worked hard for his election. Marvin Priddy, M.D., an alternate delegate to the AMA (from the 12th district), served admirably.

Uneasily, I observe the Board of Trustees becoming more "corporate." I would rather bend the corporation laws to make the Board more representative.

Specifically, legal advice would call for the Board of Trustees itself to make appointments to fill its own vacancies. Such advice would do away with the office of alternate trustee, also. Franklin A. Bryan, M.D., has been exceedingly helpful to me; I would hate to be trustee without back-up. Furthermore, other alternate trustees have made important contributions.

The Board of Trustees is more than a board; it sometimes performs as a cabinet, sometimes as a senate. In short, the board of trustees has the anatomy of a board but the physiology of a senate. I would prefer a board controlled by the districts rather than allowing a chance for the board to control itself. Which would you prefer?

The AMA continues fiscal improvement; likewise, it maintains its recent aggressive stance towards federal intervention in health care delivery. For instance, the AMA will join a state to sue the federal government to block the Health Services Agencies law. This on the basis that the "powers reserved to the states" section of the United States Constitution is violated by the "certificate of need" portion of the HSA law. (This section requires a state to demand a health care agency to complete a "certificate of need" showing a need for its planned facility with its state.)

Part two of the HSA law establishes regionalized planning panels composed of a consumer majority, thereby creating two more problems:

1. Planning has a tendency to become management (or worse, mismanagement) as demonstrated by the HSA's predecessors, HPCs.
2. Consumerism has its limits, too. Consumers are great in pointing out problems but weak in solving them because of lack of expertise in health matters, hypersensitivity to medical pressure groups and inattention to health-care politics.

My term is at an end, I have enjoyed being your trustee. You here at home and those in Indianapolis have been courteous, intelligent, diligent and helpful.

ALVIN J. HALEY, M.D.
Trustee

Thirteenth Trustee District



G. BEACH GATTMAN, M.D.
Trustee

The 13th Medical District Meeting was held at the South Bend Country Club September 9, 1975. The afternoon was full of golf, tennis, and bridge for the ladies.

The official meeting was chaired by John O. Hildebrand of South Bend, president of the 13th district. The report of the Secretary-Treasurer was given by Dr. David Spaulding of Mishawaka. The trustee report and reports of commission members who were present were given. Dr. Francis Kubik, Blue Shield representative, gave his report and Dr. Donald Chamberlain, alternate trustee, who is chairman of this area PSRO brought us up to date on progress in this area.

Dr. Vincent Santare, president elect of the ISMA, gave a short address. We also welcomed Mr. James Waggener, executive secretary, Dr. Thomas C. Tyrrell, alternate delegate to the AMA, Mr. Howard Grindstaff, field secretary ISMA, and Mr. Herbert Dixon of Blue Shield.

Election of officers followed: Dr. John W. Luce, Michigan City, president; Dr. Elmer R. Billings, Elkhart, president-elect; Dr. David Spaulding, Mishawaka, reelected secretary-treasurer; Dr. Francis Kubik, Michigan City, re-elected Blue Shield representative.

The evening program following a delicious New Orleans smorgasbord was by the Gaslight traveling group.

The next meeting of the 13th district will be Sept. 10, 1976, in Michigan City. Dr. Luce promises an interesting program for our 1976 meeting.

G. BEACH GATTMAN, M.D.
Trustee

Editor of The Journal

On the basis of estimates for income and expense for the fourth quarter of this fiscal year it is predicted that the deficit will be about $26,000. This is in relation to a budgeted deficit for this year of $41,610 and an actual deficit for last year of $32,104.

The smaller deficit is due to a combination of more income from subscriptions by senior members and non-members than was expected, together with a reduction in the printing bill of about $12,000.

There has been a reduction in number of pages of about 30%. Following a survey of journal contents, which was conducted during the fall of 1975, the Board of Trustees approved a plan to drastically reduce the size of *The Journal*. This was accomplished by eliminating features which were low in popularity and by limiting the size of the scientific articles.

The new look has been in effect for about six months. Its full effect has not been felt, since several scientific articles accepted prior to the new limits, are still to be published.

However, the limitation of scientific articles to two journal pages, except when the article is subsidized at the rate of $100 per page for pages in excess of two, has been well accepted. Two articles have been written with the limit in mind, numerous articles have been rewritten and shortened to two pages, two articles which, by their nature, have required more than two pages, have been subsidized. When the backlog of longer articles has been published, the new editorial policy will produce shorter, more concise writings and will allow the publication of more articles, at a lesser expense.

The Journal is resuming the publication of professional cards, arranged by

categories of specialties. This feature will provide a ready reference for members who are seeking specialty consultations. It will also provide a method by which members may contribute to the financial support of *The Journal*.

The Journal received the first place award in the 1975 Sandoz Journalism Program for state medical journals with circulations above 3,000. A plaque and a $500 award will be presented by a Sandoz representative at the first meeting of the House of Delegates.

FRANK B. RAMSEY, M.D.
Editor

Delegates to AMA

Indiana's delegation to the American Medical Association's House of Delegates meeting in Dallas was successful in its efforts to elect Dr. Lowell H. Steen to a full three-year term on the Board of Trustees.

Dr. Steen, a former president of the Indiana State Medical Association, served a one-year term on the Board before his reelection.

Cleveland family practitioner John H. Budd, M.D., was chosen president-elect of the American Medical Association at this 75th annual meeting of the House.

The AMA's new president-elect has been a member of the Board of Trustees for the past six years and was a delegate to the House from Ohio for 10 years before that. He is a commissioner to the Joint Commission on Accreditation of Hospitals and a past president of the Cleveland Academy of Medicine.

AMA delegates renewed their support for the Association's Medicredit proposal for national health insurance, but decided against seeking legislation to guard against the cost of catastrophic illness.

Debate on NHI highlighted various legislative proposals that came before the house in its closing hours. Discussions thus were on familiar terrain as delegates reiterated their opposition to the encroachment of government upon medical practice.

Simply put, most delegates would have the least objectionable form of government interference possible.

The support for Medicredit marked the eighth straight year delegates have endorsed the Association's proposal of tax credits to offset the purchase of comprehensive health insurance.

Medicredit would build on the existing system of private health insurance and is in stark contrast to proposals such as Kennedy-Corman that would federalize the medical care system into a monolith administered by the Social Security Administration, supported by compulsory payroll taxes and estimated to cost as much as $90 billion annually. Medicredit, the least costly NHI proposal, is estimated to cost $2.5 billion annually.

Although Medicredit was supported, some delegates urged that AMA drop any and all NHI proposals. This is the view of most grass-roots physicians, they argued.

Catastrophic health insurance, both free standing and supplementary, generated much debate on the floor of the House. The Board of Trustees was directed to proceed forthwith to design and have introduced legislation to provide for universally available catastrophic insurance coverage financed through and administered by the private health insurance industry.

In addition to NHI, the House wrestled with the whole panoply of government programs that they consider unwarranted interference in medicine.

The alphabetical bugaboos include HSAs (health systems agencies), HMOs (health maintenance organizations), PSROs (professional standards review organizations). Also, there is the Medicare-Medicaid Administrative and Reimbursement Reform Act, that would restrict the billings of hospital-based physicians, and the Federal Drug and Devices Act, that provides for fines for prescribing a drug for a use other than what is indicated on the package insert.

On each issue the House expressed its dissatisfaction and directed the board to pursue ameliorative action.

The House approved model state legislation to protect the confidentiality of medical records and to assure medical discipline.

Delegates opposed any regulations or legislation that would unfairly limit physicians' fees. At the same time, they condemned any fraud or wrongdoing by physicians under government medical programs, called for prompt prosecution of those charged with wrongdoing, and offered to assist in bringing an end to such activities.

The House strongly objected to the recent "rollback" of CHAMPUS fees. It urged members to bill CHAMPUS patients directly rather than accept the rollback to the 75th percentile of the Medicare payment formula.

In recognition of the increasing legislative activities by optometrists to obtain statutory authority to prescribe and apply eye medications, the House reaffirmed its policy that only physicians are qualified to prescribe and apply such medications, and called for efforts counteracting the optometrists' thrust.

The AMA House reaffirmed—in strong terms—its opposition to utilization review of hospital admissions within 24 hours, whether by federal PSRO regulation or rules of the Joint Commission on Accreditation of Hospitals (JCAH).

The House also adopted a policy concerning payment of physicians for utilization review. "When UR committees which are mandated by government or third party payors to review inpatient care require inordinate amounts of physician time and/or responsibility, compensation for the physician involved should legitimately be claimed."

In accepting a number of AMA budget reports, the House commended the trustees for their outstanding service in elevating the Association from the financial morass into which it had plunged in late 1974.

Jere W. Annis, M.D., the board vice chairman, reported that AMA has a current full dues-paying membership of 137,023, within close range of the 144,-500 figure upon which the 1976 AMA budget is based.

After several years' of study the delegates finished the arduous task of reorganization of the AMA's councils and committees. In addition, the office of the vice president was abolished.

In urging strong efforts to recruit additional members by year's end, Dr. Annis said that this would allow the AMA to apply about $10 million to its liquid reserves, bring the total by Nov. 30, 1976, to $18.2 million.

This is in keeping with the Association's determination to replenish its reserves, as directed by delegates at the 1975 Annual Convention, when dues were raised from $110 to $250 annually.

The House directed the board to take appropriate action—including legal action if needed—to guard against unwarranted federal intervention when the final utilization review regulations are published this fall. The delegates stopped short, however, of requiring the trustees to notify HEW at this time of its opposition to the anticipated regulations, which are currently being revised by HEW.

Strong objection to the use of any system of universal identification, including the Social Security number, for physicians and patients was made.

The AMA affirmed its opposition to any governmental mandate for examination of nursing home patients at arbitrarity predetermined intervals of time.

The AMA reaffirmed established policy that "statutory definition of death is neither desirable or necessary; death shall be determined by the clinical judgment of the physicians using the necessary available and currently accepted criteria."

The house also encouraged state medical associations to give appropriate assistance to physicians involved in countersuits to non-meritorious medical liability suits.

The delegates also approved a lengthy resolution urging JCAH to prevent hospitals from setting up rules that put authority for private patients in the hands of housestaff over the attending physician. The resolution, introduced by the New York delegation, was in response to charges by New York physicians that some hospitals were forcing

attending physicians to turn over authority for writing treatment orders for private patients to housestaff.

The new president of the American Medical Association, Dr. Richard E. Palmer, warned that the federal government is the biggest threat to the medical profession, and urged all physcians to unite in the AMA for their own protection.

The government "has made itself a rigid custodian of the people's common hopes and horizons," charged the Alexandria, Va., physician at his inaugural ceremony June 30 in Dallas.

But the federal government, having made itself the "chief arbiter of what is desirable," by now has shown that "it is far less adept in realizing possibilities, however, than in stimulating desires," Dr. Palmer said.

"Some group has to be blamed and disciplined for the embarrassing gap, and in medical care, that group is the givers of care."

He counted off failures and mistakes in federal and congressional actions regarding medicine, including the ill-fated utilization review regulations, the Health Planning and Resources Development Act, the House report on "unnecessary surgery," and the Federal Trade Commission antitrust charges against the AMA.

"Instead of settling for a reasonable adjustment to medical realities," he said, "government is becoming steadily more dogmatic."

The only way to combat federal intrusion into medicine, he said, was for physicians to unite behind the AMA in its efforts on behalf of the profession and of quality medical care.

JAMES A. HARSHMAN, M.D., JOHN O. BUTLER, M.D., MALCOLM O. SCAMAHORN, M.D., PATRICK J. V. CORCORAN, M.D., PETER R. PETRICH, M.D.—Delegates.

GEORGE LUKEMEYER, M.D., ROSS L. EGGER, M.D., EVERETT BICKERS, M.D., THOMAS C. TYRRELL, M.D., MARVIN E. PRIDDY, M.D.—Alternates.

Ad Hoc Committee on Improvement of Medical and Health Care in Jails

Your Committee is pleased to report on the status of the Jail Project, as of July 15, 1976, and request the attention and interest of the members of the Indiana State Medical Association in the future of the project.

In late 1975, the American Medical Association received a grant from the LEAA Criminal Justice Agency to carry out a pilot program. The purpose was to involve organized medicine on all levels in the establishment of the nation's detention centers, correctional institutions, with the assistance of local officials and other appropriate disciplines and professions; to develop nationally applicable medical guidelines for these institutions at the level which will insure an acceptable standard of medical care; and to establish a health and medical certification program to serve the nation's correction system.

Indiana was selected as one of the six states to carry out a pilot program. The Indiana Jail Project is sponsored by the Indiana State Medical Association, but with the close cooperation of the Indiana Lawyers' Commission, an arm of the Indiana Bar Association, and with the help of many different groups in the state. Since January 1976 much work has gone into devising a program which will, first, evaluate the present jails' conditions, and, specifically, the health care being provided, and then move towards establishing certain standards which are reasonable and practical and can lead to an ongoing program whereby all of the jails in our state may provide adequate health services and be eligible for a national certification program.

Aside from the humanitarian aspect of this project, there is an important practical consideration which has dictated urgent implementation of this type program. A quote from a local newspaper in April 1976 illustrates this, "Indiana's antiquated prison system is threatened with a costly United States Justice Department Civil Rights lawsuit unless steps are taken to correct overcrowded conditions and inadequate medical services." Some time ago, a federal mandate was given to Lake County relative to jail services. More recently, the Federal District Court for the Southern District directed that the Marion County Jail should make specific changes, including specific directions relative to medical examinations, dental care and improved health situations.

The Indiana Committee for implementing this AMA jail program selected seven counties to form the basis for its pilot studies. These counties are Marion, Lake, Greene, Monroe, Morgan, Owen and Brown Counties. The latter five counties were selected because of their contiguous nature and with the specific idea of seeing what type program might be devised which would be practical and helpful for the smaller counties in our state. Mr. Newton Goudy, a former executive secretary of the Indiana Bar Association, was selected to be the project director for Indiana. Dr. Dwight Schuster was named the medical director and Judge Fred Rakestraw, the legal director.

The first part of the project was to gather baseline data. All of the seven counties involved have been most cooperative, and this aspect of the project has now been completed and the results are being analyzed. The next general object was to develop standards for medical care and health services in jails, and this is rapidly approaching completion. The next part of the project will be the development of an inmate physical profile. This program will consist of a medical history, physical examination and brief laboratory study on all of the inmates in the small jails and a percentage of the inmates in the two larger jails, the latter to be at least 50 inmates. Making this study will form another part of our baseline data and enable us to evaluate changes and improvements in the system in subsequent years.

With the evaluation of the results obtained from the baseline data and the conferences held by representatives of the six pilot states, we will be in a position to make suggestions relative to improvements in the respective jails in the pilot program. The second and third year portions of this project will entail the expansion of the program to all the jails and the development of some means of an ongoing certification program. The response from the various sheriffs and jail officials has been most encouraging and, with the continued support of the general community and, particularly, the medical community and county officials, this program should move on to a successful completion and be of great value to all concerned.

As the chairman of the ISMA Ad Hoc Committee on Medical and Health Care in Correctional Institutions and as Medical Director of the ISMA Indiana Jail Project, I wish to express my appreciation and that of the members of the committee for the support and encouragement we have had from the officers of the Association, the limited number of ISMA members who have known about and who have been invited to participate in our work, and to Executive Director Donald Foy and his staff at the ISMA office for their valued help.

DWIGHT W. SCHUSTER, M.D.
Chairman

Reports of Committees

Executive Committee

The Executive Committee met immediately following the organizational meeting of the Board of Trustees of ISMA on the final day of the 1975 Convention at French Lick and elected Dr. Joe Dukes chairman.

A number of meetings were held during the year, both prior to meetings of the Board and between Board meetings.

The extent of items brought to the attention of the Committee and subsequent actions make it impractical to relate totally the business undertaken.

The committee, however, did deal with the operation of the Headquarters Office, clarified many policies on internal operation, such as utilization of legal counsel, arranged and participated in the annual visitation with Indiana congressmen in Washington, reviewed proposed expenditures by the Convention Arrangements Committee, made budgetary adjustments periodically, heard reports from commissions seeking funds for various projects, reviewed requests for mailing lists and served as a review body at the request of medical societies in several instances. These are broad generalizations on the Committee's activities.

The business of the Association increasingly requires more activity by the Executive Committee. Many of the Committee's actions are reflected in the activities of the Board of Trustees, to which items were referred.

The actions of the Executive Committee, although not circulated to the members, are always available to the membership upon request.

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1975, the following six cases were pending before the committee:

Case 313—Suit filed Sept. 5, 1967. Pending. (Expense to date $600.00)

Case 314—Suit filed approximately July 6, 1970. Pending.

Case 316—Suit filed July 2, 1970. Pending.

Case 321—Suit filed May 30, 1974. Pending.

Case 323—Suit filed Aug. 30, 1974. Closed. (Expense $720.00)

Case 324—Suit filed Feb. 3, 1975. Pending.

Since Aug. 1, 1975 to Aug. 1, 1976, no new cases have been filed.

2. Medical Defense Fund Statement from July 1, 1975, to June 30, 1976:

Bank Balance, July 1, 1975	$30,406.44
Receipts	4,988.89
Total cash and receipts	$35,395.33
U. S. Treasury Bonds	25,060.21
Due from General Fund	1,313.64

The Journal

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1976, as follows:

The first table shows the number of journal pages for the past five years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1971	970	70	426	30	1396	116
1972	933	69	433	31	1366	113
1973	877	73	321	27	1198	100
1974	870	69	282	31	1176	98
1975	792	71	318	29	1110	93

The table below show the total printing costs of *The Journal:*

Year	Total Printing Costs	No. of Pages (Inserts Excluded)
1972	41,789.70	1106
1973	42,642.43	1028
1974	50,895.65	1176
1975	52,742.30	1110
1976 (6 mos.)	23,360.68	436

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1976, is as follows:

Year (Jan.-June)	Sold by State Medical Journal Adv. Bureau	Sold direct By Journal	Total
1972	17,869.96	1,622.60	19,492.56
1973	10,938.94	2,134.95	13,073.89
1974	10,280.92	3,151.00	13,431.92
1975	9,250.86	3,763.16	13,014.02
1976	8,512.17	4,360.00	12,872.17

JOE DUKES, M.D., *Chairman;* RICHARD G. INGRAM, M.D., VINCENT J. SANTARE, M.D., JOHN W. BEELER, M.D., ELI GOODMAN, M.D., GILBERT M. WILHELMUS, M.D., ARVINE G. POPPLEWELL, M.D.

Future Planning

The Future Planning Committee has held three meetings, Feb. 8, Mar. 28, and May 19, 1976, all at Association Headquarters.

The committee embarked on a program to project what the ISMA should be doing the forthcoming year and in 5 and possibly 10 years. This was done with the realization that plans and programs may be subject to change, depending on current events. Since the committee was small, the majority of the membership was present at all meetings, allowing for a good and free discussion by all present.

In the initial meetings the committee discussed: (1) The provision of services by the ISMA which are attractive to members and constitute a positive program by the ISMA, (2) The fact that the Association will soon need to be dealing with PSRO, HSAs, and other governmental regulations which are appearing with increasing frequency, (3) The need for continuing and concentrated promotion and publicity to the membership concerning services provided by the ISMA, (4) The possibility of using *The Journal* as a communication vehicle with the thought of possibly including more emphasis on socioeconomic issues and practice management articles. (5) On a long range basis, consider ways of developing an alternate source of income for the ISMA. An example of this may be the possibility of providing medical management resources for physicians. (6) Consider providing each member with a ready reference guide on policies patterned after the AMA quick-reference guide. (7) The possibility of developing a computer capability by the ISMA for the collection and storage of appropriate data.

With these thoughts, the committee requested and obtained the AMA's planning process as reported in "An Overview of the AMA Planning System." This was carefully reviewed and the plan was sent to the ISMA Board of Trustees for its consideration.

It was thought by all committee members that before plans could be formulated: (1) All committee and commission chairmen be polled concerning their thoughts and suggestions regarding the direction the ISMA should be taking, each in regard to his committee or commission, (2) Member and possibly nonmember physicians be polled, and (3) A feasibility study be conducted for the ISMA concerning computer applications.

A number of the committee and commission chairmen answered the poll. These answers will be sent to the Board of Trustees for consideration and action.

The previous membership questionnaire has been reviewed and a new one developed. The questionnaire will be presented to the Executive Committee for

their consideration and review with the committee's recommendation that funds be approved to carry out the membership poll.

The ISMA is the major spokesman for all the physicians in Indiana. In order to carry out this function, the committee thought that some form of data bank and computer facilities were needed to obtain accurate answers to questions promptly. A well devised program with the proper data will allow the Board of the ISMA to obtain answers to questions concerning membership, physician distribution, etc. thereby facilitating knowledgeable decisions. It was also agreed that, if at all possible, the system be developed in such a manner that it will be self-supporting and may *possibly generate* funds for the ISMA. The protocol, concepts of a feasibility study, and cost estimates for such a study will be presented to the Board for consideration and action. It is the recommendation of the committee that funds be granted to undertake the feasibility study.

STANLEY M. CHERNISH, M.D.
Chairman

LOWELL H. STEEN, M.D., PETER R. PETRICH, M.D., E. HENRY LAMKIN, JR., M.D., WILBERT McINTOSH, M.D., JACK SHANKLIN, M.D., JOHN O. BUTLER, M.D., GARY WRIGHT (STUDENT), RANDY LEE, M.D. (RESIDENT), GEORGE ARONOFF, M.D. (INTERN).

Grievance Committee

The Grievance Committee had but one meeting within the past year and all cases pending over the past three years were brought to its attention. In several, all of the necessary action was completed and the cases were considered closed. In two cases, complaints regarding fees and reimbursements were referred to Blue Shield; their prompt action was forthcoming, the complainants were notified and both cases were closed. Only three cases of a minor nature are pending and as soon as the local medical societies have notified us of their action we hope we can close these cases also.

As in the past, we will continue to refer complaints to the local medical societies and, when appropriate, to the insurance company underwriter. With this policy, we find it unnecessary to hold numerous meetings and shall depend on the continuing cooperation and understanding of the membership.

THOMAS C. TYRRELL, M.D.
Chairman

RICHARD S. BLOOMER, M.D., EUGENE S. RIFNER, M.D., WARREN N. McCLURE, M.D., GEORGE N. LEWIS, M.D.

Medical-Legal Review

The Medical-Legal Review Committee handled a minimum of routine problems during the year without having to call a formal meeting. The committee activities were once again curtailed because of the Ad Hoc Committee which has been handling the medical liability area, which was one of the major functions of this committee.

Our association is fortunate to have this Ad Hoc Committee which has worked very diligently to provide us with P.L. 146 and the amendments passed during the last session of the General Assembly which helped strengthen the constitutionality and understandability of this law.

The Medical-Legal Review Committee is anxious to help the Ad Hoc Committee in whatever way it can.

JOHN W. BEELER, M.D.
Chairman

JOSEPH G.S. WEBER, M.D., ROBERT R. KOPECKY, M.D., GEOFFREY SEGAR, ATTORNEY, JAMES J. STEWART, ATTORNEY, WILLIAM HALL, ATTORNEY, JOHN O'CONNOR, ATTORNEY.

Fifty-Year Club—1976

ADAMS COUNTY
Herbert E. Dester, Berne

ALLEN COUNTY
William R. Clark, Fort Wayne

DELAWARE-BLACKFORD COUNTY
James U. Dodds, Hartford City
Karl E. Puterbaugh, Albany

FLOYD COUNTY
William F. Edwards, New Albany
Abraham B. Ginsherman, New Albany

GRANT COUNTY
Wendell W. Ayres, Marion
Grace B. Boyer, Marion

HOWARD COUNTY
Jesse S. Spangler, Kokomo

JACKSON COUNTY
Wm. Durbin C. Day, Seymour

JEFFERSON-SWITZERLAND COUNTY
James B. Burcham, Madison

LAKE COUNTY
Abraham A. Brauer, Griffith

MADISON COUNTY
Walter A. Laudeman, Elwood
Joseph S. Stamper, Anderson

MARION COUNTY
Eugene F. Boggs, Indianapolis
James M. Hilmer, Indianapolis
George F. Lawler, Bradenton, Fla.
Harter L. Leatherman, Indianapolis
Marlow W. Manion, Indianapolis
John M. Masters, Indianapolis
Harvey N. Middleton, Indianapolis
Morris B. Paynter, Noblesville
Harold C. Thornton, Indianapolis

MONTGOMERY COUNTY
Fred N. Daugherty, Crawfordsville

NOBLE COUNTY
Frank W. Messer, Kendallville

OWEN-MONROE COUNTY
Raymond M. Borland, Bloomington

PARKE-VERMILLION COUNTY
Emil H. Dowell, Rockville

PORTER COUNTY
Carl M. Davis, Valparaiso

PULASKI COUNTY
Harold J. Halleck, Winamac

TIPPECANOE COUNTY
Russell A. Flack, Los Angeles, Calif.

VANDERBURGH COUNTY
Clarence C. Herzer, Evansville
Harold D. Lynch, Evansville

VIGO COUNTY
Walter C. Anderson, Terre Haute
James V. Richart, Terre Haute

WAYNE-UNION COUNTY
Leon T. Cox, Richmond

WELLS COUNTY
Robert L. Johnston, Melbourne, Fla.

Reports of Commissions

Constitution and Bylaws

The Commission on Constitution and Bylaws met several times during the year and will present to the House of Delegates of the Association in October 1976, a revised Constitution and Bylaws.

The Commission, during its study of the Constitution and Bylaws, discovered much duplication of material. This new approach streamlines the Constitution, eliminates the duplications and incorporates other material currently contained in the Constitution into the Bylaws and simplifies understanding and readability of the document.

The Constitution has been printed twice in The Journal of ISMA preceding the meeting of the House, and the Bylaws will be presented to the House in October. Both documents will be contained in House of Delegates packets at the time of the annual meeting.

LESTER H. HOYT, M.D.
Chairman

THOMAS J. CORRAO, M.D., IVAN T. LINDGREN, M.D., JOHN E. FREED, M.D., C. G. CLARKSON, M.D., JOHN M. RECORDS, M.D., WALLACE A. SCEA, M.D., WILLIAM J. MILLER, M.D., FRANK M. STURDEVANT, M.D., ROBERT M. BROWN, M.D., JOHN B. GUTTMAN, M.D., MALCOLM WREGE, M.D. (deceased), GLEN WARD LEE, M.D., LLOYD L. HILL, M.D., WILLIAM R. CLARK, SR., M.D.

Legislation

The short session of the 99th General Assembly was once again, like that of 1975, a very productive one for organized medicine in Indiana.

H.B. 1310, which encompassed several technical changes to P.L. 146, was passed and signed into law by Governor Otis R. Bowen, M.D., on Feb. 25, 1976, which should strengthen the constitutionality of P.L. 146. The changes were in the areas of self insurance, annual aggregate, joint liability of employees, minimum surcharge, time limit on screening panels, and a broader definition of a health care provider. All this was accomplished through the efforts of the Medical Malpractice Study Commission, chaired by Gilbert M. Wilhelmus, M.D., which was created by the 1975 General Assembly, and the dedicated physicians of the Indiana State Medical Association who kept the legislators well informed of the need for these changes.

The Commission on Legislation will continue to study this problem, along with the Study Commission, and will initiate further changes, if change is indicated.

Another major accomplishment by your Commission, ISMA physicians, and ISMA's lobbyists Richard Guthrie and Fred Garver, was the sustaining of Governor Bowen's veto of S.B. 111, the Foreign Medical Graduates Bill.

In addition to these two bills, your Commission looked at 71 other medically related bills which could have a direct bearing on physicians and health care in the state of Indiana. None of the 13 bills on health subjects that were enacted into law were opposed by the Indiana State Medical Association through the Commission on Legislation.

The rapport between the Commission and the three physician legislators—E. Henry Lamkin, Jr., M.D., Indianapolis; Anthony Pizzo, M.D., Bloomington and Floyd Coleman, M.D., Waterloo—has been a tremendous help in accomplishing the above.

After the short session of the General Assembly ended, the Commission met in April and decided to support the Medical Licensing Board's position that it possesses the necessary authority under the Medical Practice Act to register P.A.s in Indiana and not to sponsor or support a P.A. bill during the next session if the Medical Practice Act can be used. The Commission also agreed to cooperate with the State Board of Health and State Legislative Committee in developing a certificate of need bill which would be introduced during the next session of the General Assembly.

James J. Stewart, ISMA attorney, was asked to provide the Commission with a recommended solution to the duplicate payment of registration fee for controlled substances which could be introduced at the next session of the General Assembly. The Commission also moved that Mr. Stewart be allowed to aid the Medical Licensing Board, at ISMA's expense, in setting up procedures for getting increased funds for the Board and for the promulgation of rules and regulations of the Medical Practice Act. This was approved by the Executive Committee.

The Commission then discussed substitution legislation and voted to oppose such a bill if introduced at the next session of the General Assembly. Another area of discussion was definition of death legislation. The Commission felt that an ad hoc committee, made up of physicians from the specialties who have the most knowledge in this area, should study the need for definition of death legislation in Indiana. The ad hoc committee has been appointed by Vincent J. Santare, M.D. and will report back to the Commission prior to the next session of the General Assembly.

The Commission has also asked our legal counsel to write a resolution or bill which would provide any doctor civil immunity from retrospective review, concurrent review and post review.

The Commission is scheduled to meet again on September 16, 1976, to prepare any new legislation or study new proposed legislation which could have a direct bearing on the health care delivery system in Indiana.

As chairman, I would like to take this opportunity to say thank you to all the hard working members of the commission as well as to all the others who contributed their time and energy to help support the positions taken by the Commission and your State Medical Association.

PAUL F. MULLER, M.D.
Chairman

JAMES A. MARVEL, M.D., PAUL J. WENZLER, M.D., PETER H. LIVINGSTON, M.D., WILLIAM F. BLAISDELL, M.D., WILLIAM G. BANNON, M.D., JOHN A. DAVIS, M.D., JOHN G. PANTZER, M.D., RICHARD L. REEDY, M.D., JOHN A. KNOTE, M.D., LEONARD W. NEAL, M.D., RICHARD L. GLENDENING, M.D., JERRY L. STUCKY, M.D., ROBERT M. SWEENEY, M.D., JAMES M. KIRTLEY, M.D., DON E. WOOD, M.D., MALCOLM O. SCAMAHORN, M.D., JOHN B. WHITE, JR., M.D., PHILIP N. ESKEW, JR., M.D., PELAYO B. CABRERA, M.D., JOSEPH M. BLACK, M.D., JOHN G. PANTZER, M.D., JAMES A. HARSHMAN, M.D., WALTER HUNTER.

Medical Education

The Commission on Medical Education and its Committee on Accreditation held three meetings this year. The following actions were taken:

1. Reviewed site team surveys together with accreditation request data supplied by hospitals and societies seeking accreditation. Site teams actually visited each hospital accredited.

2. Developed and began resurvey and reaccreditation processes of hospitals whose term of CME accreditation was approaching expiration date.

3. Approved CME accreditation or reaccreditation of the following hospitals and specialty societies:

*St. Joseph's Hospital, South Bend
*Memorial Hospital, South Bend
Indiana OB/GYN Society
Fort Wayne Medical Education Program (Lutheran, Parkview, St. Joseph's Hospital, Fort Wayne Medical Society)
St. Vincent Hospital, Indianapolis
St. Mary's Hospital, Evansville
Terre Haute Regional Hospital, Terre Haute
Dearborn County Hospital, Lawrenceburg
Mercy Hospital, Elwood
*Reid Memorial Hospital, Richmond

Indiana Urological Society
Aesculapian Society, Terre Haute
**St. Margaret's Hospital, Hammond

4. Reviewed scientific programs of 1976 ISMA State Convention and approved as Category I, Accreditable Material in the AMA, PRA.

5. Issued distinguished membership cards to recipients of PRA. In the first 6 months of 1976, 253 PRAs were awarded to Indiana M.D.s, as compared to 125 in like period of 1975.

6. Accredited a total of 23 Indiana hospitals and 11 specialty societies in Category I programs.

7. Recommended consideration by ISMA Trustees that CME participation become prerequisite to ISMA membership.

8. The following Commission members provided liaison with other groups:

Indiana Medical Licensure Board
Ernest R. Beaver, M.D.
Accreditation Committee Chairman
Eugene M. Gillum, M.D.
AIDME
John L. Cullison, M.D.
Division of Postgraduate Education of I.U.
John Phillips, M.D.
Convention Arrangements
Russell L. Judd, M.D.
John Roscoe
Family Practice
Eugene M. Gillum, M.D.
Representative to Board of Trustees
Franklin Bryan, M.D.
Student Affairs
Phillip Doering
House Staff
Robert Rankin, M.D.
Commission on Legislation
Steven C. Beering, M.D.

Commission on Medical Education

STEVEN C. BEERING, M.D.
Chairman

ROBERT H. OSWALD, M.D., GEORGE N. LEWIS, M.D., RICHARD RIEHL, M.D., LESLIE M. BAKER, MD, ROBERT OEHLER, M.D., DAVIS W. ELLIS, M.D., DONALD M. SCHLEGEL, M.D., EUGENE M. GILLUM, M.D., LINDLEY WAGNER, M.D., NICHOLAS L. POLITE, M.D., SHOKRI RADPOUR, M.D., RONALD H. SCHEERINGA, M.D., WALLACE S. TIRMAN, M.D., ERNEST R. BEAVER, M.D., FRANKLIN A. BRYAN, M.D., JOHN L. CULLISON, M.D., JOHN ROSCOE, JOHN PHILLIPS, M.D., ROBERT RANKIN, M.D., PHILLIP DOERING, CLEON SCHAUWECKER, M.D.

*Extension or reaccreditation
**Has been surveyed and in all probability will be approved at the September meeting.

Submission on Accreditation

EUGENE M. GILLUM, M.D.
Chairman

JOHN CULLISON, M.D., MICHAEL A. HOGAN, M.D., DONALD M. SCHLEGEL, M.D., WILLIAM FECHTMAN, M.D., EMMETT C. PIERCE, M.D., WILLIAM D. RAGAN, M.D., RAYMOND O. PIERCE, M.D., JEFFREY KELLAMS, M.D., CHARLES HELMEN, M.D., NORMAND T. TOWNLEY, M.D., WILLIAM G. BANNON, M.D., RUSSELL L. JUDD, M.D., DONALD F. MacLEOD, M.D., JOHN V. OSBORNE, M.D., STEVEN C. BEERING, M.D., FRANKLIN A. BRYAN, M.D., DAVIS W. ELLIS, M.D., SHOKRI RADPOUR, M.D., JOHN ROSCOE

Medical Services

The Commission on Medical Services has held three meetings since the reorganization of ISMA commissions and committees. The Commission on Medical Services has spent most of its effort in evaluating previous responsibilities so as to better address the proper management of these responsibilities under the new structure. Previous program areas that were assigned to the newly constituted Commission on Medical Services include:

Emergency Medical Services
Aging
Public Health
Voluntary Health Agencies
Sports and Medicine
Governmental Medical Services
Medical Economics and Insurance

Dr. Lowell Hillis was appointed vice chairman of the Commission on Medical Services. Paul Inlow and Martin O'Neill represent the Board of Trustees on this commission.

Aging

No subcommission on aging was developed. Problems of aging will be worked on when specific projects are developed. One area for possible activity will be the development of a project for aging physicians—specifically, to develop a training program or programs for physicians to function as medical directors for nursing homes.

Sports and Medicine

Following the success of the ISMA efforts of 1975 in this field, some difficulty has been encountered in maintaining the momentum of this program. The difficulty is centered mostly in developing an ongoing group of medical leadership. It is hoped that difficulties can be resolved and the program be carried forward in the near future.

Voluntary Health Agencies

The activities of the previous Commission on Voluntary Health Agencies were all thought to be worth preserving and they were placed under the new Subcommission on Voluntary Health Agencies. The Subcommission on Voluntary Health Agencies approved 14 agencies of statewide organizations concerned with health problems. Approved are:

American Cancer Society, Indiana Division, Inc.
American Diabetes Association, Indiana Chapter
American Heart Association, Indiana Affiliate, Inc.
American Lung Association of Indiana
Arthritis Foundation, Indiana Chapter
Hemophilia of Indiana, Inc.
Indiana Committee to Combat Huntington's Disease, Inc.
Indiana Easter Seal Society for Crippled Children
Indiana Society for the Prevention of Blindness
Kidney Foundation of Indiana, Inc.
Mental Health Association in Indiana
National Cystic Fibrosis Research Foundation, Indiana
The National Foundation, March of Dimes
National Multiple Sclerosis Society, Indiana Chapter

Emergency Medical Services

The commission on Medical Services spent some time reviewing the history of emergency medical services in Indiana and assessing the current situation to determine the proper role or roles for ISMA and the Commission on Medical Services related to future development of emergency medical services in Indiana. For the past two and a half years the Governor's Commission on EMS has assumed the responsibility in this area previously held by the Indiana State Board of Health. Their first area of endeavor has been in the provision of ambulance service and development of a curriculum to train and certify paramedical professionals in that field. The Governor's Commission is now developing criteria for categorization of hospital services. These have been reviewed and endorsed by the Indiana State Hospital Association. The Commission on Medical Services is not aware of having been contacted for input in this matter. The role of the ISMA should be established at least by the Board of the ISMA. At present there does not seem to be any formal relationship other than sporadic communication between ISMA and the Governor's Commission.

There has been established a voluntary health agency known as the American Trauma Society. The society has an Indiana division. No application for approval as a voluntary health agency has

been submitted to the ISMA as yet. Perhaps further communication to this end should be established.

Insurance

No action developing a captive company providing medical liability insurance is felt to be necessary at this time in light of the availability of such insurance coverage from commercial carriers. The Commission will keep abreast of the marked legislative and judicial actions in this area and make recommendations where appropriate.

Implementation of Resolution 75-5, ISMA Members' Self-Insurance Plan, has begun. Since this would require a budget and staff, an investigation must be undertaken before recommendations along this line can be made by the Commission on Medical Services. A membership opinion questionnaire developed by the Future Planning Committee will, if approved by the Board of Trustees, seek information from members concerning their interest in various forms of insurance coverage under an ISMA captive company or agency.

Governmental Medical Programming

CHAMPUS—Dr. Andrew Offutt is now consultant to the Indiana CHAMPUS program. James Waggener is also serving in the position of administrator of this program.

Dr. Offutt reported CHAMPUS computer programming has been revised to that of the Medicare system although still administered nationally by the CHAMPUS Division of the Department of Defense headquartered in Denver, Colo. The major practical significance is that fees are based on the 75th percentile, Medicare data, whereas previously the basic guideline was the California relative value scale in most instances. Dr. Offutt has expressed Indiana's opposition to the new scale. In Indiana, CHAMPUS has processed 27,500 claims in 1975 through the ISMA intermediary function.

Dr. Offutt requested guidelines from the Commission on Medical Services for adjudicating claims for ileal bypass surgery. The Commission on Medical Services approved the following criteria:

TO: ALL CHAMPUS Providers
FROM: Indiana State Medical Ass'n. (CHAMPUS)
SUBJECT: Ileal Bypass Surgery

1. It is necessary that criteria be established on which an evaluation may be made for CHAMPUS claims based on above surgery. Because of this need certain claims presently being held for utilization review will be subjected to these criteria. If such a claim is pending from your practice you will receive a request to furnish the required information.

2. Criteria include:
 a. The patient must be at least 50% or 100 pounds overweight, whichever is greater.
 Morbid obesity is defined as a condition in which the presence of excess weight causes physical trauma; where pulmonary and circulatory insufficiencies are present; where complications exist related to the treatment of such conditions as arteriosclerosis, diabetes, coronary disease, etc.; and where the person is 50% or 100 pounds overweight.
 b. The morbid obesity must have existed for at least 5 years.
 c. Nonsurgical methods of weight reduction must have been attempted under a physician's supervision.
 d. The patient must be between 15 and 60 years of age. Note: If the patient is under 30, special attention should be given to letters "b" and "c," above.
 e. There must be good indications that the patient will remain hyperphagic postsurgically.

3. Where cases involve other aspects, it will be necessary to request additional information and review before providing benefits. It is to be noted that submission of the criteria above does not ensure affirmative action on the claim.

A committee to advise Dr. Offutt on CHAMPUS problems was established and includes five doctors: Paul E. Humphrey, Terre Haute; Albert M. Donato, Indianapolis; R. James Bills, Gary; Paul M. Inlow, Shelbyville, and Lee H. Trachtenberg, Munster. Specialists were to be consulted as needed.

Before renewal of the CHAMPUS contract in September 1977, the Commission on Medical Services should review the contract and compare it to the previous contract, if time permits. Recommendation should be made to the Board and/or the House of Delegates if enough time is allowed. Particular concern should be whether or not it is advisable for ISMA to continue its role as intermediary in the CHAMPUS program.

Dr. Donato reviewed Medicare and Medicaid and felt that a subcommittee should meet to establish a program for modifying the procedures to obtain state financing for health projects. The area looks promising and the work is continuing—all to be reported at a later date.

Public Health

A committee has met with Dr. Offutt and other knowledgeable people concerning public health in the state of Indiana as to the status of the swine vaccine for Indiana citizens and where the vaccine will be distributed. This is a difficult problem because the situation is mercurial from day to day. A blue-ribbon committee of five knowledgeable members of the State Medical Association plus five members from the Health Department of Marion County is keeping abreast of the situation and will make its best recommendations to Hoosier physicians and citizens as the situation develops.

Commission on Medical Services

LEE H. TRACHTENBERG, M.D. *Chairman*

WALLACE M. ADYE, JR., M.D., ROGER F. ROBISON, M.D., EVERETT E. BICKERS, M.D., ROBERT O. ZINK, M.D., PAUL E. HUMPHREY, M.D., ROBERT E. TAUBE, M.D., ALBERT M. DONATO, M.D., THEODORE R. HAYES, M.D., ROBERT W. VERMILYA, M.D., R. JAMES BILLS, M.D., LOWELL J. HILLIS, M.D., R. WYATT WEAVER, M.D., JACK W. HANNAH, M.D., PAUL M. INLOW, M.D., WILLIAM R. GREENE, M.D., SARA THOMAS, ANDREW C. OFFUTT, M.D.; MARTIN J. O'NEILL, M.D.

Subcommission on Sports and Medicine

R. WYATT WEAVER, M.D. *Chairman*

WALLACE M. ADYE, JR., M.D., JACK M. WALKER, M.D.

Subcommission on Voluntary Health Agencies

ROBERT W. VERMILYA, M.D. *Chairman*

MRS. RALPH MILBURN, MR. HAROLD WARD, CHARLES W. McCLARY, M.D., CHARLES RUSHMORE, M.D., LAWRENCE E. ALLEN, M.D., RUSSELL GRAF, M.D., WENDELL W. AYRES, M.D., WALFRED A. NELSON, M.D.

Subcommission on Insurance

ROBERT O. ZINK, M.D. *Chairman*

JACK HANNAH, M.D., WILLIAM CAST, M.D., THOMAS J. CONWAY, M.D.

Public Relations

The Commission on Public Relations met three times during the year 1976. The first meeting was essentially an organizational meeting on goals. At the first meeting, a review of the ISMA welcoming packet was undertaken and it was thought that this should be updated by the staff and be available for the new physicians in the state. A motion was made to have the new packets sent to the Trustee of each district, who would, in turn, give them to the presidents of the county medical societies for distribution to the new doctors in the area.

The Health Insurance Association of America sent a letter to the State Medical Association entitled "Your Health Insurance." It was moved that the State Medical Association continue having this pamphlet available for physicians in the state of Indiana. It was also passed that an appropriate charge be made to regain the cost of the printing.

For the first time, a member of the Student Medical Association at Indiana University was appointed to the Commission. Mr. George Alcorn was appointed by the Indiana University branch of the Student Medical Association. His input was welcomed at these meetings.

The Commission also requested the Executive Committee to establish and publish a policy for relationships with laboratories, in view of the recent kickback scandals. The Commission also approved and sent to the Executive Committee its approval and recommendation that the Indiana State Medical Association take part in the Bicentennial issue of the Indianapolis Star to be published on July 4, 1976. A motion was made and approved that an ad depicting medicine in Indiana be placed in the July 4 issue.

At the final meeting of the Commission, the Speaker's Bureau was discussed and the following motion was made: The Indiana State Medical Association should renew its relationship with the Hopkins Syndicate with a ceiling of $15,000 per year for speaking engagements. The staff of the ISMA would approve each speaking engagement and a quarterly report be made to the Commission concerning speaking engagements, reception of the speakers and costs. It was also thought that spot announcements on controversial issues could be used in the field of radio and television and this was to be investigated as to cost and feasibility by staff.

One of the carry-overs from 1975 was the accountability session. The Commission discussed this at all three meetings and at the final meeting made a motion that the State Medical Association appoint a committee of five members to meet and listen to any individual or group that wanted to express ideas about improving medical care in Indiana. The committee would be instructed only to listen and to report to the House of Delegates anything they felt to be noteworthy. They were not to debate or discuss any issue with the participants. This was to be held the day before the opening of the Indiana State Medical Association annual meeting in October and each group or individual would be given five minutes to give their report. This motion was passed and sent to the Board of Trustees for approval. It was subsequently learned that in June the Board of Trustees turned this accountability session proposal down.

The Commission then took up the Medicare pamphlet, and it was decided that the Association delay any updating of the Medicare pamphlet until Congress decides what changes, if any, it is going to make.

I wish to thank the members of this committee who provided excellent service and input into the function of this Commission. The one disappointment was the turning down of the accountability session, which we believed would be good public relations with the people in the state. We hope this can be brought up again in a formal resolution at the House of Delegates with the State Medical Association deciding on this point.

JOHN W. LUCE, M.D.
Chairman

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Resolution No. 76-17

Introduced by: Ninth District Medical Society

Subject: ISMA DUES INCREASE FOR FUNDING OF TEL-MED

Referred to:

Whereas, The Indiana State Medical Association's Tel-Med program has become its greatest and most successful public relations service; and

Whereas, An average of 600 tapes per day are requested and played; and

Whereas, Schools, church organizations and the general public at large have accepted and used this service; now, therefore be it

Resolved, That there be a $20.00 increase in ISMA dues for calendar year 1977, specifically allocated for funding of continuing operation of the Tel-Med program.

Resolution No. 76-18

Introduced by: Lake County Medical Society

Subject: LEGAL PROTECTION FOR PHYSICIANS PERFORMING HOSPITAL MEDICAL STAFF FUNCTIONS

Referred to:

Whereas, there is considerable concern that the individual physician, performing various hospital medical staff functions, may be personally liable for such actions; and

Whereas, there is an increasing demand by hospitals on its medical staff to participate in such activity, notably in Utilization Review; and

Whereas, current Indiana law provides immunity for physicians only for retrospective review, while legislation in a number of other states includes both retrospective and concurrent review; and

Whereas, relatively few hospitals have provided "hold harmless" resolutions and/or extensions of their own professional liability insurance policies to embrace the activities of the medical staff officers and committees; now, therefore be it

Resolved that the House of Delegates urges the Commission on Legislation to prepare and seek adoption in the 1977 Indiana General Assembly, laws to provide total immunity for physicians from personal liability for services rendered as officers and commmittee members on hospital medical staffs; and be it further

Resolved that the Indiana State Medical Association seek immediate help from the Indiana State Hospital Association in obtaining protective action from the hospitals in the adoption of "Hold Harmless" resolutions and/or the extension of the institutions' professional liability insurance to protect physician staff members from personal liability for their actions as officers and committee members of the medical staff.

Resolutions

Resolution No. 76-1

Introduced by: Board of Trustees
Subject: GENERIC SUBSTITUTION OF A PRESCRIBED DRUG
Referred to:

Whereas, The patients of America have the right to expect that medications prescribed for them will be therapeutically effective; and

Whereas, Generic substitution of a prescribed drug may result in a patient receiving a drug which, although chemically equivalent, is not therapeutically equivalent; and

Whereas, There are documented instances in which generically and chemically equivalent drugs varied so greatly in therapeutic equivalence that the health and well-being of patients was endangered (for example, generic equivalents of Digoxin); and

Whereas, The Office of Technology Assessment of the United States Government has stated "Current standards and regulatory practices do not insure bioequivalence"; now therefore be it

Resolved, That the Indiana State Medical Association be opposed to generic substitution for a prescribed drug being done at the discretion of a pharmacist; and be it further

Resolved, That the Indiana State Medical Association make this organizational policy known to the legislature of the state of Indiana and to the AMA.

Resolution No. 76-2

Introduced by: Vanderburgh County Medical Society
Subjectt: SCOLIOSIS SCREENING PROGRAM
Referred to:

Whereas, Approximately 11% of all school children develop scoliosis between the ages of 10 and 13; and

Whereas, When curvature of the spine is permitted to progress beyond 60 degrees, life expectancy is reduced by half; and

Whereas, The condition in adults is quite difficult and expensive to treat; and

Whereas, Severe deformity can be prevented if the condition can be identified and followed when a child is between the ages of 10 and 13; and

Whereas, Screening can be carried out quickly and effectively by properly trained laymen; now, therefore, be it

Resolved, That the Indiana State Medical Association develop and implement a statewide scoliosis screening program for Indiana schoolchildren in grades 5 through 8.

Resolution No. 76-3

Introduced by: LaPorte County Medical Society
Subject: CREATION OF A COUNTERSUIT FUND
Referred to:

Whereas, The current epidemic of malpractice suits has included many specious cases where the filing of the suits by patients and their attorneys has caused much unjust expense, unfavorable publicity and other damages to the defendants; and

Whereas, These specious cases have been filed by attorneys and patients with little risk of retaliation by the defendants; and

Whereas, It is in the interest of all physicians to encourage the defendants in specious suits to countersue the responsible lawyers and patients for resulting damages in an effort to discourage such irresponsible filing of law suits; now, therefore, be it

Resolved, That the Indiana State Medical Association shall create a fund to aid doctors in the cost of countersuits by increasing the dues by $25.00 per year. The fund will be used to pay legal fees incurred in countersuits of clients and lawyers for damages, suffering, etc., as well as barratry. Legal expenses recovered from successful lawsuits will be returned to the fund.

Resolution No. 76-4

Introduced by: Tippecanoe County Medical Society
Subject: FEE MEDIATION WITH INSURANCE COMPANIES
Referred to:

Whereas, The agreement regarding fees for medical services is a matter between the patient and doctor; and

Whereas, The insurance payment is a matter between the patient and the insurance company; and

Whereas, A difference between the amount of the fee and the amount of the insurance payment may be caused by either too high a physician's fee or too low an insurance payment; and

Whereas, The existence of an informed citizenry is best promoted by the patient's continuing to maintain his personal relationship with both the physician and the insurance company; and

Whereas, The insurance industry maintains no counterpart to county societies' Insurance Committees, whereby the physician would be able realistically to obtain the help of the industry to alter the practice of those insurance companies whose fee schedules and criteria for payment are grossly inadequate; therefore, be it

Resolved, That the Indiana State Medical Association and component county medical societies shall continue to mediate in fee questions between patient and physician and shall discontinue undertaking mediation in questions over fees arising between insurance companies on the one hand and physicians or physicians' organizations on the other hand.

Resolution No. 76-5

Introduced by: Section on Allergy of ISMA
Subject: CREATION OF A DEPARTMENT OF ALLERGY AND IMMUNOLOGY
Referred to:

Whereas, 25 to 30% of patients seen by pediatricians are for an allergic problem; and

Whereas, More time is lost from school by children and teenagers because of allergic disease than from any other cause; and

Whereas, There are an estimated 50,000 asthmatics in Marion County alone; and

Whereas, Every state surrounding Indiana has medical schools with departments of allergy and immunology and accredited training programs in allergy and immunology; and

Whereas, Indiana University School of Medicine has no such department of allergy and immunology nor training program in this subspecialty; and

Whereas, Because of this, graduates of Indiana University School of Medicine are deficient in their ability to diagnose and treat allergic disease to the detriment of 15% of the population of Indiana; and

Whereas, Also because of Whereas No. 5, those interested in furthering their training in allergy and immunology must leave the state for this training and seldom return to Indiana to practice; and

Whereas, This has created a severe shortage of trained allergists in the state so that patients must frequently travel many miles and wait long periods of time to be seen and evaluated by properly trained men so that many go without proper care because of this scarcity of doctors trained to understand and care for these specialized problems; and

Whereas, Since allergy training now consists of conjoint Board of Allergy and Immunology and is a subspecialty in either internal medicine or pediatrics, and consists of two years of training in either of these specialities followed by two years training in allergy and immunology; therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association vote favorably on a resolution to use whatever means are possible to overcome this deficit which degrades Indiana University School of Medicine as a proper

training center for doctors and is not in the true interest of the citizens of Indiana; and be it further

Resolved, That a Department of Allergy and Immunology and residency or fellowship training program in the same be created at the Indiana University School of Medicine; and be it further

Resolved, That the members of the Section on Allergy of the Indiana State Medical Association promise their support in helping train these men, inasmuch as properly treated allergy patients seldom require hospitalization (such as the prevention of status asthmaticus in most patients by proper allergic management) and most allergic problems are office or clinic problems; and be it further

Resolved, Therefore, that we shall be happy to assist in proper preceptorship programs and lectures and conferences to supplement residency training programs so that Indiana University School of Medicine will not be looked upon as a second-rate medical school because of this. Ultimately, the citizens of Indiana will greatly benefit from this and this is the reason the taxpayers support a medical school in Indiana.

Resolution No. 76-6

Introduced by: Steuben County Medical Society

Subject: ISMA AS A COLLECTIVE BARGAINING AGENT

Referred to:

Whereas, Third party medical payments in Indiana are generally determined by the third party with the physicians having little or no input; and

Whereas, The payment scale varies by geographic area in the state at the discretion of the third party payer; and

Whereas, The individual physician has neither the time, finances nor influence to successfully bargain with most large third party payers; and

Whereas, Other states have successfully established their state medical societies as collective bargaining agents; and

Whereas, It is becoming more apparent that the physician in Indiana needs a collective bargaining power; therefore be it

Resolved, That the Indiana State Medical Association move to establish itself as a collective bargaining agent for all third party medical payers in Indiana for the physicians in Indiana.

Resolution No. 76-7

Introduced by: DeKalb County Medical Society

Subject: REJECTION OF CONTINGENCY FEE CONCEPT

Referred to:

Whereas, The contingent legal fee is utilized by attorneys in most malpractice suits; and

Whereas, The utilization of such a fee system contributes to the acceptance by attorneys of many non-meritorious cases; and

Whereas, Such a fee system also prompts some attorneys to magnify the nature of their clients' injuries in order to win high awards; and

Whereas, The aforementioned points contribute to the growing complications of medical malpractice as well as to professional liability problems of other professional groups; now, therefore, be it

Resolved, That the DeKalb County Medical Society, in uniform agreement, presents to the Indiana State Medical Association this resolution and requests that the ISMA record its rejection of the contingency fee concept in suits against the medical practitioner and all other professional groups in the state of Indiana; and be it further

Resolved, That the ISMA work through the appropriate legislative and other channels to implement the objectives of this resolution.

Resolution No. 76-8

Introduced by: Marion County Medical Society

Subject: ETHICS IN MEDICAL LIABILITY CASES

Referred to:

Be It Resolved, That the Indiana State Medical Association study the circumstances of individual medical liability actions to disclose unethical practices; and be it further

Resolved, That unethical practices by lawyers disclosed in this manner be referred to this Association's legal counsel for definitive action.

Resolution No. 76-9

Introduced by: Marion County Medical Society

Subject: ESTABLISHMENT OF SECTION ON NEUROLOGICAL SURGERY

Referred to:

Whereas, Neurosurgical care has become an integral part of medical care delivery system in Indiana and the nation; and

Whereas, The neurosurgeons of Indiana are concerned with the recruitment and retention of qualified neurosurgeons for the citizenry of Indiana; and

Whereas, The American Medical Association, recognizing the need to provide neurosurgical physicians a forum within the federation, has established a Commission on Neurological Surgery; and

Whereas, The American Medical Association of Neurological Surgeons is an active national organization for neurosurgical physicians; therefore, be it

Resolved, That the House of Delegates of the Indiana State Medical Association establish an official Section of Neurological Surgery of this Association.

Resolution No. 76-10

Introduced by: Marion County Medical Society

Subject: MEDICINE'S ROLE IN HEALTH INSURANCE AND PATIENT/PHYSICIAN CONTACTS

Referred to:

Be It Resolved, That the Indiana State Medical Association denounce the use of the "usual and customary" concept for determination of payment to satisfy the requirements of the contract which exists between a patient and his physician; and be it further

Resolved, That this association provide medical representatives as advisors to labor and management in future negotiations of medical benefits in an effort to combat the spiraling cost of medical care.

Resolution No. 76-11

Introduced by: Board of Trustees, St. Joseph County Medical Society

Subject: ISMA REPRESENTATIVE TO HEALTH SYSTEMS AGENCIES

Referred to:

Whereas, The Health Planning and Resources Development Act, (PL 93-641) has become law and Health Services Agencies (HSAs) are being formed and funded; and

Whereas, The HSAs in Indiana are already developing many planning programs and initiating Health Care Projects which will affect both physicians and their patients; and

Whereas, HSAs will also be associated with PSROs and other governmental projects and organizations; and

Whereas, Physicians are in a difficult minority position on the consumer oriented boards and cannot be expected to be fully acquainted with all HSA activities; and

Whereas, Physicians on the HSA boards do not officially represent organized medicine and are not in a position to provide all necessary communication with each County Medical Society; therefore, be it

Resolved, That the ISMA apply a full-time representative to each (total 3) HSA, and that this representative be acquainted with all HSA activities and inform and advise the county medical societies of the various projects as they arise, and he represent the physician as the HSA develops programs and he will attempt to achieve proper physician representation

on committees and at appropriate meetings, and he will be directly responsible to all county medical societies associated with the specific HSA involved; and it further

Resolved, That each of the representatives be hired and guided by the ISMA, but be responsible to the majority members of the county medical societies in the specific HSA.

Fiscal Note: Cost of implementation would depend upon the salary established for each representative and associated expenses. Total maximum expenditure, $90,000, although it could be reduced to approximately half this cost if part-time people are employed.

Resolution No. 76-12

Introduced by: Owen-Monroe County Medical Society

Subject: COUNTY SOCIETY DELEGATE APPORTIONMENT

Referred to:

Whereas, The Owen-Monroe County Medical Society has 112 doctors, the distribution being 110 from Monroe County and 2 from Owen County; and

Whereas, This represents a tremendously unequal distribution of physicians; and

Whereas, The present Constitution and Bylaws, Chapter IV, Section 2, states "except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county"; and

Whereas, This provides unequal representation in regard to county boundaries; therefore, be it

Resolved, That Chapter IV, Section 2, be deleted and delegates and alternate delegates from each county medical society be chosen without regard to county boundaries.

Resolution No. 76-13

Introduced by: ISMA Commission on Public Relations

Subject: ACCOUNTABILITY SESSION

Referred to:

Whereas, The Commission on Public Relations feels the general public needs to know their views on health care are respected and solicited; and

Whereas, The Commission on Public Relations feels there is need for a mechanism for the general public to express their opinions on Indiana health care, both good and bad; and

Whereas,The Commission on Public Relations feels there is a need for the State Medical Association to know what these opinions are, therefore, be it

Resolved, That the House of Delegates of the Indiana State Medical Association vote favorably to include an accountability session as part of the annual meeting; and be it further

Resolved, That the committee appointed to listen to the general public be instructed that they are not to debate or discuss any issue brought before them, and be it further

Resolved, That any item they feel is noteworthy should be reported to the House of Delegates for action or information.

Resolution No. 76-14

Introduced by: ISMA Commission on Medical Services

Subject: BILLING PROCEDURES UNDER MEDICAID

Referred to:

Whereas, Billing procedures under the Medicaid program are complex; and

Whereas, This complexity is especially noticeable in billing for nursing home care and involves both the filing of forms for Medicare and Medicaid; and

Whereas, The intricacy of the billing procedure has resulted in a quagmire of confusion leaving physicians without realistic guidelines, and the Medicaid administration does not offer a consistent voice in explaining the regulations for billing; and

Whereas, Such confusion requires repetitive filing of complicated forms; and

Whereas, Such confusion effectively deters many physicians from participating in the Medicaid program because of the inefficient use of time, overutilization of personnel, and general loss in economies for the government, the physician, and the patient; therefore, be it

Resolved, That the Indiana State Medical Association urge the Medicaid administration to develop a simplified billing procedure that is adaptable and practicable.

Resolution No. 76-15

Introduced by: ISMA Commission on Medical Services

Subject: PATIENT VISITS MANDATED BY MEDICAID

Referred to:

Whereas, The Medicaid program mandates that a physician with patients in a skilled nursing home see each of them at least every 30 days; and

Whereas, The same program requires the physician to evaluate every 60 days the patient in an intermediate care facility; and

Whereas, Such mandates depreciate the physician's professional judgment to provide the necessary medical care for patients in nursing homes; and

Whereas, The individual patient's condition requires an exercise of professional judgment not lending itself to standardization of visits by the physician; and

Whereas, In honoring these regulatory mandates, there has been engendered considerable misunderstanding, inexpedient evaluations by the Medicaid administration, and loss of compensation for such visits; therefore, be it

Resolved, That it be a matter of record that the Indiana State Medical Association opposes such mandatory visits as abrogating professional judgment in the provision of patient care and that necessary action will be initiated to eliminate this mandate from the regulations.

Resolution No. 76-16

Introduced by: ISMA Commission on Medical Services

Subject: UTILIZATION REVIEW COMMITTEE

Referred to:

Whereas, Many Indiana physicians are currently serving on utilization review committees for nursing homes; and

Whereas, Medicaid regulations require periodic patient review to determine the classification of patients as to their need for care in skilled or intermediate care nursing homes; and

Whereas, Once the classification of patients is completed, it is reviewed by government representatives; and

Whereas, Upon review, these classifications are, not infrequently, declared to be improperly determined; and

Whereas, Such data-based reclassifications by others than the utilization review committee are deemed an unwarranted usurpation of the professional judgment of physicians familiar with the patient's condition and needs; therefore, be it

Resolved, That the Indiana State Medical Association communicate with the appropriate government bodies involved in the administration of Medicaid and advise them that steps should be taken to insure the finality of the utilization review committee's action; and be it further

Resolved, That should legislation be necessary to effectuate the above, then the House of Delegates shall instruct the Board of Trustees of ISMA to begin immediate action to achieve these objectives.

Additional resolutions appear on page 711.

Scientific Exhibits

Kenneth G. Kohlstaedt, M.D.
Indianapolis
Chairman

THE HEALTH ADMINISTRATOR—FRIEND OR FOE?

Exhibitor: Graduate School of Administration
I.U. School of Medicine
Indianapolis

Attendants: Jack Broyles, Don Klusmeier, Dick Cota, Greg Lintjer and Rob Weathers

The men and women of the Graduate Program of Health Administration, the newest division of Indiana University School of Medicine, will discuss the vital role of the health administrator in the delivery of quality health care.

ORTHOPAEDIC SIMULATORS TO ENHANCE PSYCHOMOTOR SKILL

Exhibitor: G. Paul DeRosa, M.D.
Orthopaedic Department
I.U. School of Medicine
Indianapolis

Co-Exhibitors: Merrill A. Ritter, M.D., Craig Gosling

Attendants: G. Paul DeRosa, M.D.
Merrill A. Ritter, M.D.
Craig Gosling

This exhibit displays four (4) orthopaedic patient simulators that have been developed at Indiana University for the teaching of medical students and paramedical personnel:

Simulator #1 is called "Hippy." It is the simulator to teach proper examination and diagnostic technics for congenital dislocation of the hip.

Simulator #2 is called "Liggy." Liggy represents the lower extremity of a 14-year-old athlete that can be "programmed" to simulate various tears of the collateral and cruciate ligaments about the knee.

Simulator #3 is "Tibby." Tibby represents a fracture of the tibia and fibula in a 14-year-old child. The model is able to be manipulated so that reduction can be achieved and plaster casts applied.

Simulator #4 is "Colly." This simulator allows students and practioners alike the opportunity to feel a Colles' fracture and to practice manipulation of this fracture.

This particular exhibit has been well received at the American Academy of Orthopaedic Surgery Meeting in February 1976 in New Orleans and at the AMA Meeting in Dallas, Texas, in June-July 1976. It should provide much teaching information and opportunities for the participants of the meeting to get a "hands on" feel for several of the more common lesions in orthopaedic surgery.

THE DIAGNOSIS OF OVARIAN CARCINOMA: SPECIFIC AMYLASE ELEVATIONS SERUM AND TUMOR ENZYME LEVELS

Exhibitor: M. E. Hodes, M.D., Ph.D.
Department of Medical Genetics
I.U. School of Medicine
Indianapolis

Co-Exhibitors: Mr. Steve Morgan
Dr. Robert C. Karn
Dr. A. D. Merritt
Dr. C. Ehrlich

Attendants: M. E. Hodes, M.D., and Steve Morgan, B.S.

The exhibit will show a picture of a recumbent woman with ascites. Blood is being drawn for serum amylase determination and for electrophoretic determination of amylase isozyme patterns—elevated *salivary* amylase indicates possible ovarian tumor. Ascites fluid is also being removed. After centrifugation the cells in the pellet are cultured and the amylase level and isozyme pattern of the supernatant fluid determined. At operation, ovarian (tumor) tissue is removed and examined for amylase level and type, and examined histochemically and by an immune technic for amylase antigen. Elevated salivary amylase indicates the possibility of ovarian carcinoma.

FROM THOUGHT TO ACTION—AN EXAMPLE OF CURRICULUM DESIGN AND IMPLEMENTATION

Exhibitors: Nancy A. Roeske, M.D.
Hugh C. Hendrie, M.D., Ch.B.
Department of Psychiatry
I. U. School of Medicine
Indianapolis

Attendants: Faculty of Department of Psychiatry, I.U. School of Medicine

The exhibit will demonstrate the many steps involved in developing an educational program. The example will be a course, Examination of the Personality, which is constructed for individual student learning or for use by an instructor with a group of students. The cooperative collaboration of persons from a variety of professions, psychiatrists, actors, audiovisual directors, and producers and publicity art designers will be demonstrated. The viewers will have an opportunity to see the finished product and have an individual learning experience. Monitors will be available and the course will be presented. Faculty from the Department of Psychiatry will be available to discuss the course with the viewers of the exhibit.

ABDOMINAL MASSES IN BABIES: A NEW TEACHING MODEL

Exhibitor: Jay L. Grosfeld, M.D.
James Whitcomb Riley Hospital for Children
Indianapolis

Co-Exhibitor: Thomas V. N. Ballatine, M.D.
James Whitcomb Riley Hospital for Children

Attendant: Secretary from the Section of Pediatric Surgery

The purpose of this exhibit is to present a new diagnostic teaching modality: a baby abdominal mass simulator. The soft model "baby" has easily palpable masses (smooth, nodular, solid, compressible). Four baby simulators are available for "physical examination" and are surrounded by x-ray and clinical pathological photographs as a background to correlate these findings.

The idea for the simulator was derived from the "DO NOT PALPATE ABDOMEN" signs placed on the cribs of infants with suspected neoplasms to prevent possible metastases. Due to this clinically important preventive measure, very few students and house officers in training have the opportunity to palpate these lesions that require early diagnosis. These models were successfully used during the second year physical diagnosis course at the Indiana University School of Medicine and have great potential as a teaching adjunct.

SCOLIOSIS SCREENING—A MUST FOR INDIANA

Exhibitor: Indiana Orthopaedic Society
George F. Rapp, M.D., Indianapolis
Bryant A. Bloss, M.D., Evansville

Attendants: George F. Rapp, M.D., and Bryant Bloss, M.D.

Scoliosis screening is a practical approach to the prevention of severe deformities, which may occur later in the life of children. The screen process should come between Grades 3 and 8, and if curves can be detected before they become severe, surgery can usually be avoided, particularly in the idiopathic type of scoliosis.

In the state of Delaware, where a screening program has been in effect for several years, the operative treatment of idiopathic scoliosis is practically nil.

It is our hope that we can stimulate interest in the physicians in the state of Indiana to set up a similar type program here. Thirty seconds spent in screening a child may prevent a lifetime of disability.

RADIONUCLIDE EVALUATION OF ACUTE INTRASCROTAL SWELLING

Exhibitor: Jerry L. Kight, M.D.
Department of Radiology
Division of Nuclear Medicine
Methodist Hospital
Indianapolis

Co-Exhibitors: Larry L. Heck, M.D.
Thomas Riley, M.D.,
Indianapolis

Attendants: Jerry Kight, M.D.
Larry L. Heck, M.D.
Thomas Riley, M.D.

The differential diagnosis of acute intrascrotal swelling is multiple and varied. The diagnosis can usually be made by a good history and physical examination. At other times, a definitive diagnosis is impossible — especially testicular torsion versus epididymitis. Prompt, accurate diagnosis can save a testicle or save the patient a scrotal exploration.

Radionuclide imaging of the testicles using Technicium Pertechnetate to evaluate blood supply has proven to be an invaluable modality in those cases where the diagnosis is clinically in doubt. The procedure can be done easily, rapidly and with low radiation dose to the patient in any nuclear medicine imaging laboratory.

The diagnostic accuracy approaches 98% in differentiating torsion from epididymitis. Tumors and abscesses can and have been diagnosed utilizing this procedure, although diagnostic accuracy is less. The accuracy rate does vary not only with the pathology, but with the age of the patient—i.e., testicle size.

The exhibitors feel that this procedure would be of great value in the armamentarium of every physician who deals with the typical intrascrotal lesion.

THE ARTIFICIAL AIRWAY: INDICATIONS AND MAINTENANCE IN ACUTE RESPIRATORY FAILURE

Exhibitor: Lawrence M. Lampton, M.D.
I.U. School of Medicine
Indianapolis

Co-Exhibitors: Vernon Vix, M.D.
Cara Denney, R.N., M.S.
Richard E. Brashear, M.D.

Attendants: Exhibitors

This is an educational exhibit making the maximal use of audiovisual aids (illustration, roentgenograph, color fiberoptic bronchoscopy slides on a rear-view projector, and handouts) to demonstrate the advances in acute respiratory failure management both before and after intubation.

A variety of artificial airways, ranging from oropharangeal airways thru endotracheal tubes, esophageal obturators and tracheostomy tubes to post-tracheostomy devices, are demonstrated. The indications, contraindications, advantages and hazards of each are discussed. A variety of artificial airway tracheal cuffs (conventional cuffs, low compliance floppy cuffs, and baffle cuffs) are demonstrated along with a discussion of cuff management technics.

The management technics and equipment used in establishing a patent upper airway in early acute respiratory failure are illustrated and discussed.

Illustrations demonstrating proper intubation technics using both the laryngoscope for the oral route and the fiberoptic bronchoscope for the nasal route are presented. Frequent and little recognized complications (ala nasi necrosis, acute sinusitis, acute otitis media, aerophagia, aspiration, bleeding, etc.) of intubation are presented and technics for minimizing them are discussed and demonstrated by illustration and radiographs. Complications and management associated with trachestomy are similarly presented.

Little recognized problems of increased respiratory failure secondary to endotracheal tube obstruction by kinking, by collapse from torsion or cuff compression and by cuff occlusion are illustrated.

The criteria and technics for extubation are presented. Post extubation complications are illustrated and presented.

CONTINUING MEDICAL EDUCATION—WAT 21—SURGICAL GRAND ROUNDS AT THE INDIANA UNIVERSITY SCHOOL OF MEDICINE

Exhibitor: Thomas V. N. Ballatine, M.D.
James Whitcomb Riley Hospital for Children
Indianapolis

Co-Exhibitor: Elmer Friman, Medical Resources Program, I. U. School of Medicine

Attendants: Medical Education Resources Program Personnel

This exhibit demonstrates an important adjunct in the field of Continuing Medical Education for the surgical specialist. It is oftentimes difficult or impossible for the active practitioner of surgery to participate in surgical meetings or in operative procedures which may take place in another hospital. Through the medium of videotape, a given procedure is recorded within the operating rooms on the Indiana University Medical Center Campus. A mobile unit can, in fact, tape a procedure anywhere in the state. The surgeon may then, at his leisure, edit the tape until only the salient features are recorded.

At a later date, the surgeon-discussant and his medical colleagues meet at the studios of WAT-21 in University Hospital at Indianapolis. A typical grand rounds presentation is developed using a case presentation, slides, etc., with the addition of the videotaped procedure. At the end of the formal discussion there is a question-and-answer period between the discussants within the studio and with the 21 hospitals where the program is being shown live. The entire package is consolidated into a one-hour program which is then available to any of the 84 hospitals with videotape playback capability. Thus, the surgeon is able to keep abreast of current thinking in such disorders as childhood cancer, carcinoma of the thyroid, testicular tumors, etc., without any great inconvenience. It is anticipated that this modality will increase in its effectiveness as more and more physicians throughout the state recognize its utility.

The exhibit will demonstrate previous tapes of WAT-21 Grand Rounds in Surgery. Appropriate schedules will be available.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



Valium®
(diazepam) Ⓘⓥ

2-mg, 5-mg, 10-mg scored tablets

in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MEDICAL MUSEUM NOTES



By virtue of the old Pathology Building's inclusion in the National Register of Historic Places, Central State Hospital, Indianapolis, was designated an official Bicentennial Area, and the Indiana Department of Mental Health became eligible for federal support for participation in the Bicentennial celebration. The official American Revolution Bicentennial flag was presented to Central State Hospital and the Indiana Department of Mental Health by Mr. Del Black, director of Region V of the American Revolution Bicentennial Commission. The ceremony occurred on June 23, 1976. Other participants included the Honorable William Hudnut, mayor of Indianapolis; William E. Murray, M.D., commissioner of the Indiana Department of Mental Health; Mr. Eric Helmer, superintendent of Central State Hospital, and Mr. Gary Lucas of the Indiana American Revolution Bicentennial Commission. The flag now flies from the old Pathology Building.

The bicentennial program of the Indiana Department of Mental Health is being presented in cooperation with the Department of Psychiatry of Indiana University School of Medicine. This program consists of three public forums which are to be presented in the amphitheater of the Old Pathology Building. The general theme of the three-part program is "Rights of the Mentally Ill and Community Responsibility." They are being sponsored by the Indiana committee for the Humanities in cooperation with the National Endowment for the Humanities. The program is as follows:

Public Forum #1
Tuesday, Sept. 21, 1976, 7:30 p.m.
Historical Development of Mental Health Care
Keynote Address:
Governor Otis R. Bowen, M.D.
Moderator
Professor John Riteris
Department of Philosophy, IUPUI
Panelists:
William E. Murray, M.D.
Indiana Mental Health Commissioner
Dr. Douglas Steeples, Chairman
Department of History, Earlham College

Public Forum #2
Tuesday, Oct. 19, 1976, 7:30 p.m.
The Development of State Hospitals and Treatment
Moderator:
Professor John Riteris
Panelists:
Charles A. Bonsett, M.D.
Neurologist
Hugh C. Hendrie, M.B., Ch.M.
Psychiatry Department, I.U.M.C.
Dr. Marcus Reidel
Philosophy Department, Valparaiso University

Public Forum #3
Tuesday, Nov. 16, 1976, 7:30 p.m.
Future Plans for Care and Treatment
Moderator:
Professor John Riteris
Panelists:
Dr. Bernard Bogar, Chairman, Department of Economics, IUPUI
Dr. Edmund Byrne
Department of Philosophy, IUPUI
Dr. Nancy Roeske
Associate Professor of Psychiatry
I.U. School of Medicine

The nucleus of the three forums is a series of 10 panels which attribute progress in the care of the mentally ill to the influence of the American Revolution and Dr. Benjamin Rush; outline the development of systematic care for the mentally ill in America; show the role of Indiana in this development, and outline the future of mental health care in Indiana. These panels have been executed by Hoosier artist William G. Ashby and will remain as a permanent exhibit in the Indiana Medical History Museum when the forums have been completed.



PARTICIPANTS in the official presentation of the Bicentennial flag to the Indiana Department of Mental Health and Central State Hospital on June 23 were (from left to right): Mr. Lucas, Mr. Black, Dr. Murray, Mayor Hudnut and Mr. Helmer.—Photo courtesy Jim Brown.

When impotence due to androgenic deficiency is driving them apart



Android®-5 Buccal Tabs
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Methyltestosterone U.S.P. – 5, 10, 25 mg.

New Double-Blind Study ANDROID-25 *vs.* Placebo*

* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy,* Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly,* pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

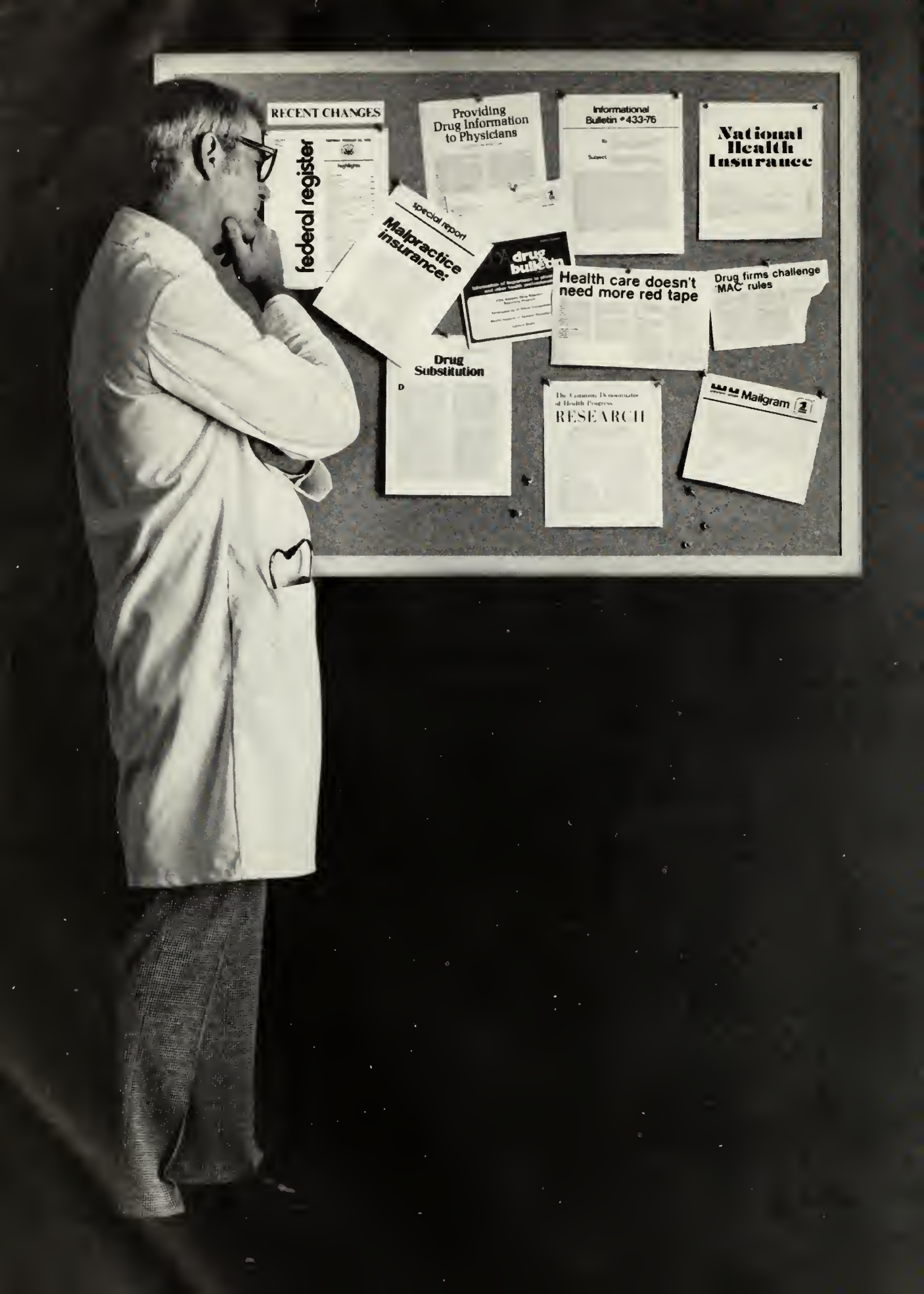
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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for vertigo*


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Testing in Humans: Who, Where & When.

the weight of ethical opinion:

Few would disagree that the effectiveness and safety of any therapeutic agent or device must be determined through clinical research.

But now the *practice* of clinical research is under appraisal by Congress, the press and the general public. Who shall administer it? On whom are the products to be tested? Under what circumstances? And how shall results be evaluated and utilized?

The Pharmaceutical Manufacturers Association represents firms that are significantly engaged in the discovery and development of new medicines, medical devices and diagnostic products. Clinical research is essential to their efforts. Consequently, PMA formulated positions which it submitted on July 11, 1975, to the Subcommittee on Health of the Senate Labor and Public Welfare Committee, as its official policy recommendations. Here are the essentials of PMA's current thinking in this vital area.

1. PMA supports the mandate and mission of the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research and offers to establish a special committee composed of experts of appropriate disciplines familiar with the industry's research methodology to volunteer its service to the Commission.

2. PMA supports the formation of an independent, expert, broadly based and representative panel to assess the current state of drug innovation and the impact upon it of existing laws, regulations and procedures.

3. When FDA proposes regulations, it should prepare and publish in the *Federal Register* a detailed statement assessing the impact of those regulations on drug and device innovation.

4. PMA proposes that an appropriately qualified medical organization be encouraged to undertake a comprehensive study of the optimum roles and responsibilities of the sponsor and physician when company-sponsored clinical research is performed by independent clinical investigators.

5. PMA recognizes that the physician-investigator has, and should have, the ultimate responsibility for deciding the substance and form of the informed consent to be obtained. However, PMA recommends that the sponsor of the experiment aid the investigator in discharging this important responsibility by providing (1) a document detailing the investigator's responsibilities under FDA regulations with regard to patient consent, and (2) a written description of the relevant facts about the investigational item to be studied, in comprehensible lay language.

6. In the case of children, the sponsor must require that informed consent be obtained from a legally appropriate representative of the participant. Voluntary consent of an older child, who may be capable of understanding, in addition to that of a parent, guardian or other legally responsible person, is advisable. Safety of the drug or device shall have been assessed in adult populations prior to use in children.

7. PMA endorses the general principle that, in the case of the mentally infirm, consent should be sought from both an understanding subject and from a parent or guardian, or in their absence, another legally responsible person.

8. Pharmaceutical manufacturers sponsoring investigations in prisons must take all reasonable care to assure that the facilities and personnel used in the conduct of the investigations are suitable for the protection of participants, and for the avoidance of coercion, with a respect for basic humanitarian principles.

9. Sponsors intending to conduct non-therapeutic clinical trials through the participation of employee volunteers should expand the membership and scope of its existing Medical Research Committee, or establish such an internal Medical Research Committee, with responsibility to approve the consent forms of all volunteers, designs, protocols and the scope of the trial. The Committee should also bear responsibility to ensure full compliance with all procedures intended to protect employee volunteers' rights.

10. Where the sponsor obtains medical information or data on individuals, it shall be accorded the same confidential status as provided in codes of ethics governing health care professionals.

11. PMA and its member firms accept responsibility to aid and encourage appropriate follow-up of human subjects who have received investigational products that cause latent toxicity in animals or, during their use in clinical investigation, are found to cause unexpected and serious adverse effects.

12. PMA supports the exploration and development by its member companies of more systematic surveillance procedures for newly marketed products.

13. When a pharmaceutical manufacturer concludes, on the basis of early clinical trials of a basic new agent, that a new drug application is likely to be submitted, a proposed development plan accompanied by a summary of existing data, would be submitted to the FDA. Following a review of this submission, the FDA, and its Advisory Committee where appropriate, would meet with the sponsor to discuss the development plan. No *formal* FDA approval should be required at this stage. Rather, the emphasis should be on identification of potential problems and questions for the sponsor's further study and resolution as the program develops.

The PMA believes that health professionals as well as the public at large should be made aware of these 13 points in its Policy on Clinical Research. For these recommendations envisage constructive, cooperative action by industry, research institutions, the health professions and government to encourage creative and workable responses to issues involved in the clinical investigation of new products.

P·M·A
Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
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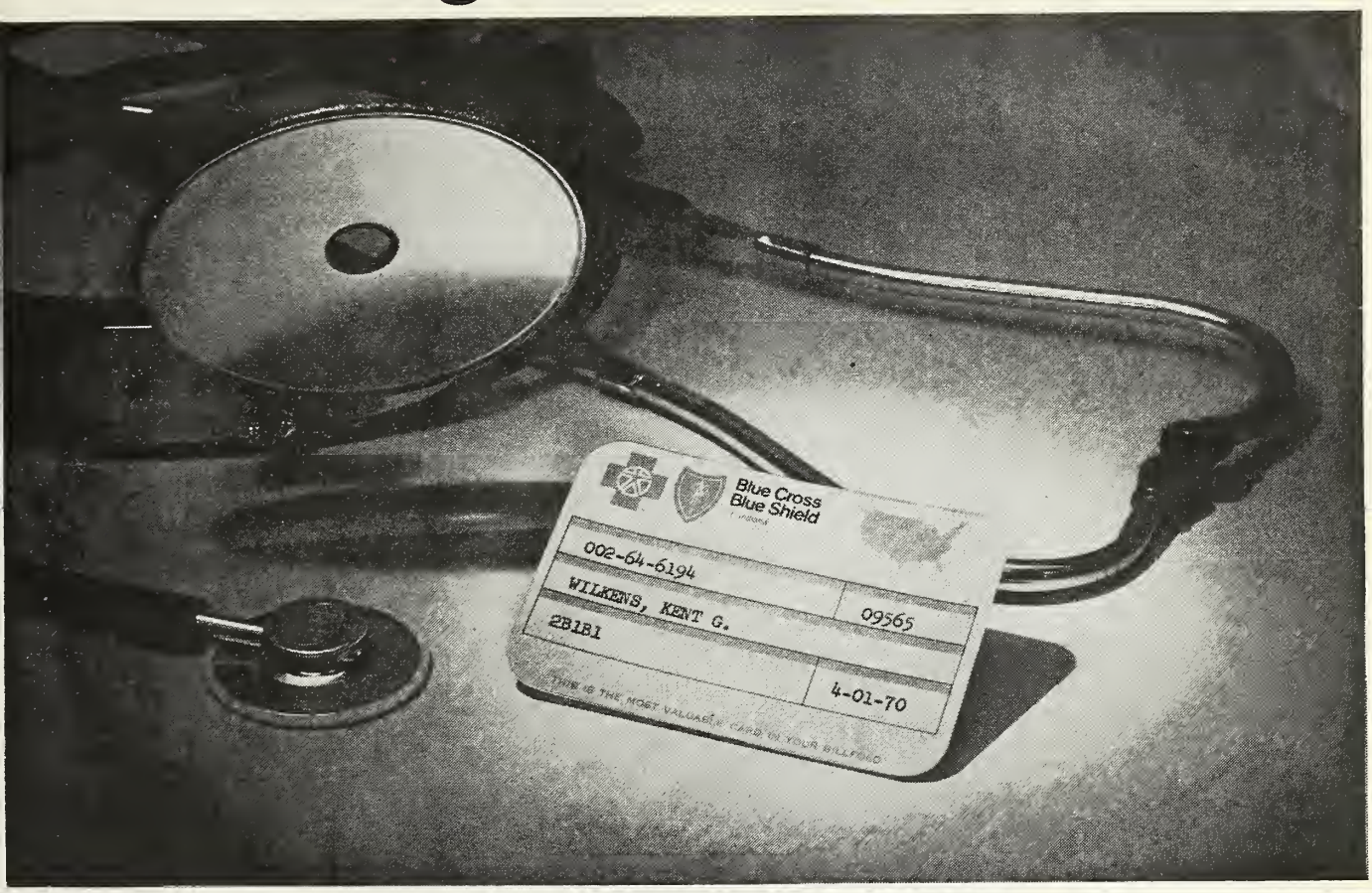
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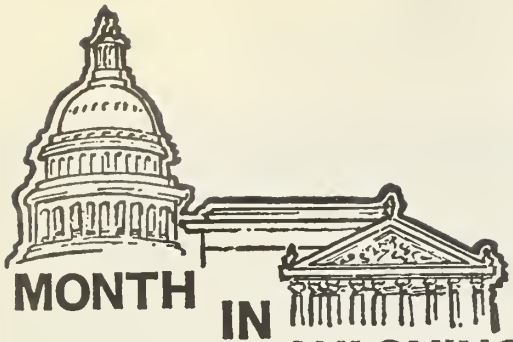
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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

SEPTEMBER IS NOW THE APPOINTED MONTH for the Congress to make final disposition of a great deal of unfinished health legislation. The August doldrums saw little visible Congressional action on health business. But behind closed doors much work was performed by members and staff in committee and conference meetings. However, the final shape and form of legislation such as manpower, health maintenance organizations, clinical laboratories, Indian health, variable incentive pay, and emergency medical services will not be known until the last hectic days of the 94th Congress as it rushes to adjourn and go home for the autumnal election campaigns.

The Maximum Allowable Cost (MAC) drug program went into effect towards the end of August with little visible activity. First signs of life will probably appear in the late fall when MAC's advisory committee will meet to consider the initial prescription drugs for the program.

Court decisions in the various countersuits, including that of the American Medical Association, are not expected in the near future.

The three-year-old brainchild of former Health, Education, and Welfare Secretary Caspar Weinberger, MAC sets price ceilings on certain widely used drugs in an effort to discourage prescription of brand-name products. Physicians would have to stipulate that brand-name drugs for Medicare-Medicaid beneficiaries are medically necessary on the prescription in order to prevent the pharmacist from filling the order with the lower cost generic drug. In states with anti-substitution laws, patients would have to make up the difference in price if a brand-name is ordered.

MAC had been scheduled to go into effect four months ago, but retail druggists joined drug manufacturers and the AMA in protest, causing the four-months postponement.

In a letter to HEW Secretary David Mathews, the Pharmaceutical Manufacturers' Association said the original postponement was to resolve "confusion and opposition" surrounding MAC. "It is our observation that such hopes have not been realized, and in fact, the situation is even more chaotic today," said PMA President C. Joseph Stetler.

The AMA and PMA have a consolidated suit against MAC pending in Chicago District Court. Other litigation has been launched by the National Association of Retail Druggists (NARD), the Private Medical Care Foundation, Inc., and Congress of County Medical Societies. Citing these, along with a petition filed with HEW on July 27 by the American Pharmaceutical Association (APHA), and the "continuing concern," and "growing dissatisfaction" of many individuals and organizations, Stetler said, "there is every reason to further delay . . . the MAC program."

The MAC proposal has many controversial aspects, not the least of which is the fact that it was an administrative decision without any legislative backing in the language of the Medicare and Medicaid laws. Thus, one of the criticisms is that it represents "government by regulation" and violates the Medicare law's prohibition against intereference.

Weinberger claimed MAC would save the government $60 million a year, but another former HEW Secretary, Robert Finch, disputed the claim. Finch, now a private citizen in California, said the bureaucratic cost-of-running the program would offset any possible savings. In a letter to the *Wall Street Journal* last year, Finch also argued that bioequivalency cannot be demonstrated at present. The MAC regulations pose "the key question of whether the patient receives the exact prescription the doctor ordered," he wrote.

Physicians for the most part will be affected with Medicaid patients, since there is no substantial outpatient benefit for Medicare drugs.

In addition to the control program, HEW will send all physicians a list of most frequently prescribed drugs along with the prices community pharmacies pay for them.

No federal sanctions are provided for physicians who decide to write out the "medically necessary" prescription message.

Before a Maximum Allowable Cost can be established for drugs, the Food and Drug Administration must first indicate that there are no bioequivalence problems among its several brands. The HEW Pharmaceutical Reimbursement Board would then propose a MAC at a level equal to the lowest cost at which the drug is generally available to providers. Before the MAC can be established officially it must be reviewed by a non-governmental advisory committee and published in the *Federal Register* for comment.

The regulations establish both the Pharmaceutical Reimbursement Board and the five-member outside advisory group.

HEW said about one-fourth of commonly prescribed drugs are available from multiple sources. However, the number for which bioequivalence problems can be ruled out is smaller.

The reimbursement that a pharmacist receives for drugs he provides Medicare and Medicaid patients will be based on an estimate of his cost of buying the drug plus a dispensing fee, or on his usual charge to the general public, whichever is the smaller. Program agencies such as the state Medicaid program would make the estimates according to price information supplied on a regular basis by HEW.

Druggists protested a HEW wholesale price list designed to guide state agencies which the druggists said contained "out-of-date" low prices.

John Ball, M.D., assistant to the director of FDA's Office of Quality Standards, recently said it may be as long as six months before the first small group of drugs has gone through the process for declaring them ready for MAC.

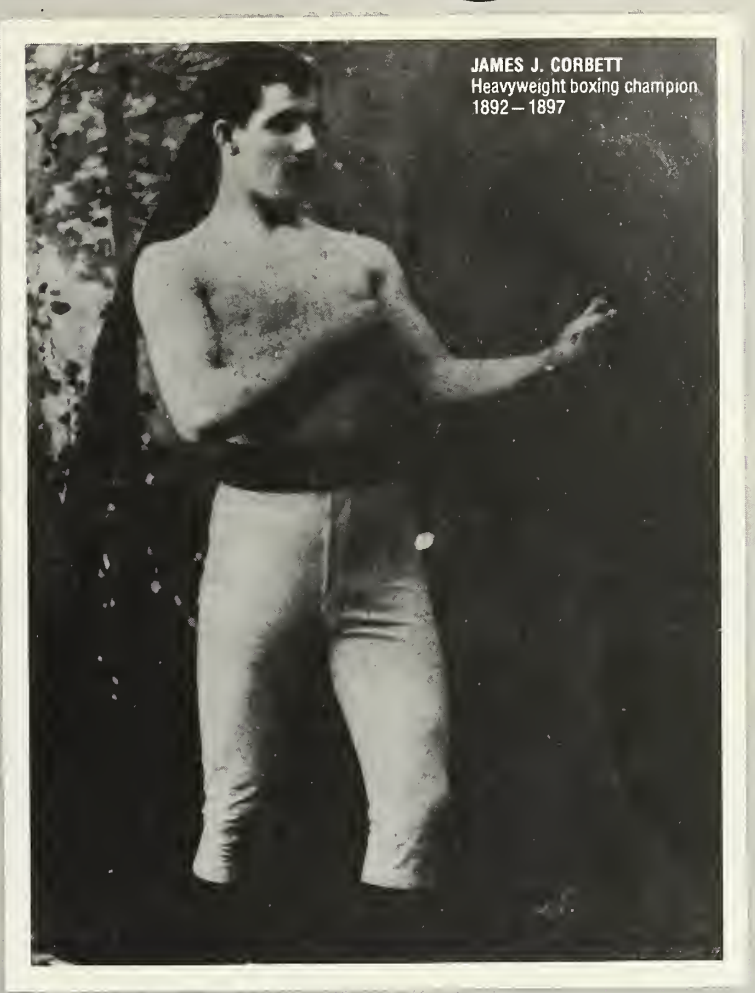
THE REPUBLICAN PARTY HAS GONE ON RECORD against compulsory National Health Insurance. The platform plank on health adopted by the delegates at the convention in Kansas City was in sharp contrast to the Democratic plank endorsing a comprehensive national plan financed by regular and Social Security taxes.

The GOP statement on health supported extension of catastrophic protection "to all who cannot obtain it." The private health insurance system should be utilized to "assure adequate protection for those who do not have it," the platform said. "Such an approach will eliminate the red tape and high bureaucratic costs inevitable in a comprehensive national program."

President Ford this year did not renew his previous endorsement of the Nixon Administration's NHI plan calling for employers to provide employees with comprehensive private health insurance, federalizing Medicaid, and subsidizing a catastrophic benefit. Instead, Ford asked Congress for a catastrophic benefit for Medicare beneficiaries. He said the so-called mandated plan would be too expensive at present.

Continued on page 728

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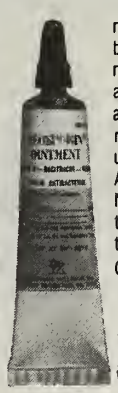
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Complete literature available on request from Professional Services Dept. PML.



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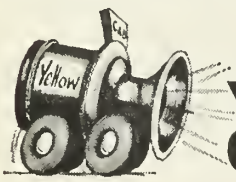
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On abortion the Republicans supported "the efforts of those who seek enactment of a constitutional amendment to restore protection of the right of life for unborn children." The Platform conceded that the issue "is one of the most difficult and controversial of our time . . . undoubtedly a moral and personal issue" involving "complex questions relating to medical science and criminal justice."

The Supreme Court's ruling on abortion permitting it until the last stages of pregnancy was "an intrusion into the family structure through its denial of the parents' obligation and right to guide their minor children," said the Platform.

THE HOUSE HAS PASSED THE SO-CALLED toxic substances act which gives the Environmental Protection Agency new powers to prevent hazardous chemicals from being marketed. A provision was added on the House floor to ban within two years the manufacturers of polyChlorinated biphenyls (PCBs.) The chemical has been found in fish in the Great Lakes and the Hudson River and traces discovered in humans. PCBs are used in electrical equipment and enter the food chain through waste dispersal in waterways.

The HEW Department has awarded contracts to establish five centers for health planning in Madison, Wis.; Columbia, Mo.; Denver, San Francisco, and Boise, Idaho. The contracts, totaling $3.2 million, will provide training and consultation to health planners in 24 states, Guam, American Samoa and the Trust Territories of the Pacific. HEW established five other centers for health planning earlier this year in Boston; Syracuse, N.Y.; Fort Washington, Pa., Atlanta, and Houston.

THE HOUSE WAYS AND MEANS SUBCOMMITTEE on Health has postponed until mid-September hearings on issues involved in increasing physicians' fees and possible revisions in the present reasonable charge reimbursement system used in the Medicare program.

The Subcommittee will hear testimony on:

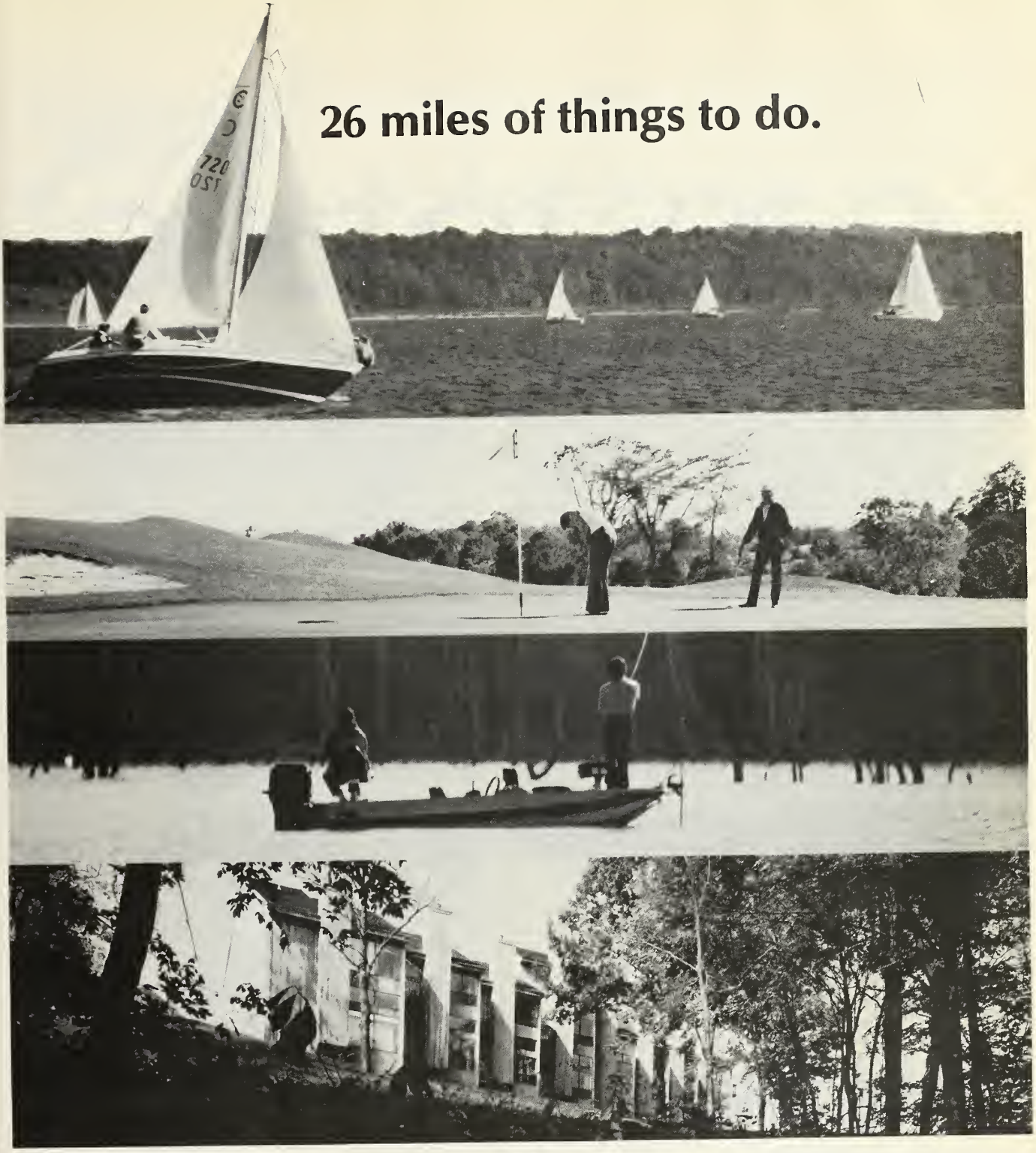
Factors in the present system which influence physicians to accept assignment or to direct bill; advantages and disadvantages to requiring physicians to accept assignment in any case; factors contributing to geographic variations in physicians' reasonable charges, including differences in urban and rural charges; implications of the differences in charges between primary care physicians and specialists, and the effect of such fee differences on the selection of certain specialties by physicians; feasibility and desirability of reimbursing physicians on a fee schedule basis and the factors which would be used to adjust the schedules to reflect the variation in physicians' cost of practice; the role of relative value scales in determining physician fees; results of experimental reimbursement programs, and comments on legislation already pending which would amend Medicare reimbursement of physicians.

PRESIDENT FORD HAS NAMED Robert Nelson Smith, M.D., Toledo, Ohio, anesthesiologist, to be assistant secretary of defense for health affairs. Dr. Smith, who served as President of the Ohio State Medical Association in 1969-1970, succeeds James Cowan, M.D., who resigned.

Dr. Smith graduated from West Point in 1943 and served in the Air Force from 1943 to 1948. He received a Master of Science degree from Massachusetts Institute of Technology in 1945 and his medical degree from the University of Nebraska College of Medicine in 1952.

The 56-year-old physician is a member of the AMA, the Ohio State Medical Association and the American Society of Anesthesiologists. ◄

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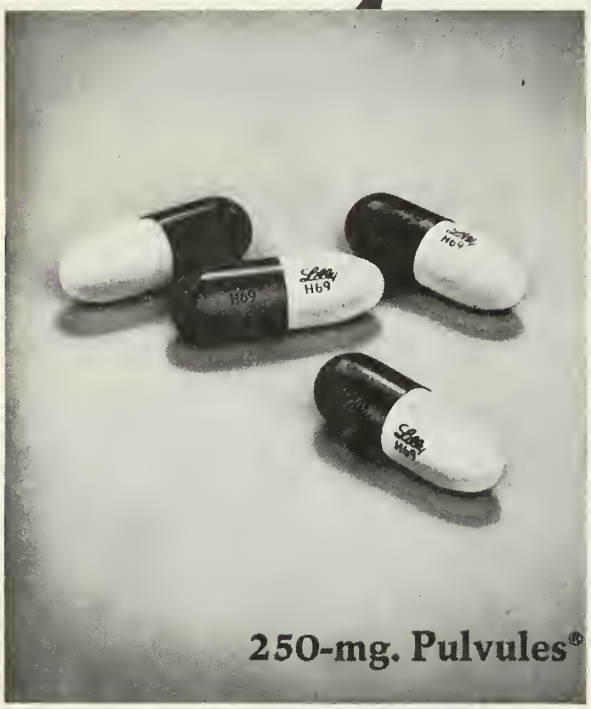
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

Volume 69—October 1976—Number 10

"Everything a cell does, it does because of an enzyme." When we know all about all enzymes medicine will be much simpler.

Sandhoff's Disease: A Case Report Including Family Study And Fetal Enzyme Determination

VIMALKUMAR PATEL, Ph.D.
IRA BRANDT, M.D.
RAY ANTLEY, M.D.
WOLFGANG ZEMAN, M.D.
Indianapolis

SANDHOFF'S disease is a recently recognized gangliosidosis with a clinical picture virtually identical to that of Tay-Sachs disease. Diagnosis is established by the absence of both the A and B forms of hexosominidase activity from serum and tissues, whereas only the A form is deficient in the prototype disorder. Since the original description[1] about 10 cases have been described in the literature.[2,3,4,5]

This report describes a family in which hexosaminidase studies demonstrated the autosomal-recessive nature of the disorder and provided additional evidence for the reliability of fetal diagnosis.

Case Report

R.L.W., the firstborn child of healthy, unrelated parents, grew and developed normally after an uneventful gestation until the age of 4 months. Subsequently physical growth continued at a normal rate but his sensory motor development slowed progressively and by the time he was first examined at the age of 11 months, his psychomotor function was severely retarded. He required support in order to sit and couldn't crawl or stand. He was irritable and wakeful. Wheezing respirations were noted at night.

The family history revealed that a maternal granduncle had died at the age of two years after an illness his mother described as "nearly identical" with that of the patient.

Physical examination at 11 months of age revealed that he was of average weight; his length was about 95th percentile and his head circumference was the mean for his age. His craniofacial appearance initially was considered a bit unusual, in that his head was broad posteriorly but narrowed anteriorly, there was a metopic ridge, his nasal bridge was slightly depressed, the eyes slanted upward slightly, and his features were somewhat coarse. The resemblance to his father was striking, however. There were no teeth. His elbows could not be fully extended. A small umbilical hernia was present. His liver was palpable but not considered to be enlarged. The deep tendon reflexes were moderately hyperactive. The remainder of the examination was entirely within normal limits except that a cherry-red spot was seen in both retinas and that he could not sit without support nor could he say "da-da," which he had previously been able to do.

Laboratory studies: A blood smear did not reveal any inclusion bodies, and the routine complete blood count was normal. Urinalysis was normal, as were the urine ferric-chloride, dinitrophenylhydrazine, reducing-substance, cyanide-nitroprusside and toluidine-blue tests. Urinary amino acids showed a moderate generalized increase. Radiographic examinations of the lumbar spine and hands were normal. White blood cell analysis for hexosaminidase revealed only 14% of the activity of 15 age-matched controls, and heat inactivation studies at 50° C revealed normal proportion of A and B components of the activity.

His subsequent course was characterized by progressive deterioration of psychomotor performance

From the Departments of Pathology, Pediatrics and Medical Genetics, Indiana University School of Medicine, Indianapolis, Indiana 46202.

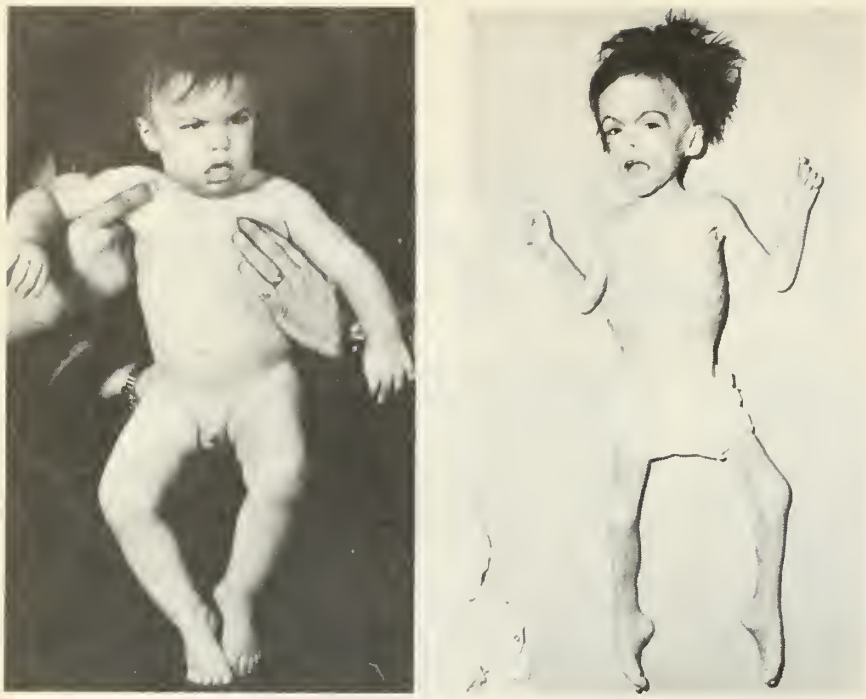


FIGURE 1.
Photographs of R.L.W., patient with Sandhoff's disease, taken at the age of 11 months (left) and 21 months (right). Note the emaciation.

and physical status. He had several infections, both respiratory and viral, although not more frequently than a normal child. These require admission, however, because of difficulty in swallowing and his progressively emaciated state (Fig. 1). At age 21 months he weighed 6.7 kg and had difficulty sucking and swallowing. He was quite unhappy and had a monotonous cry. Constant chewing movements were noted. Hyperacusis was noted. His tongue now showed fasciculations. There was prominent hirsutism and the pigmentation of his skin had deepened. His head circumference was 49.3 cm (approximately 0.5 S.D. above the mean). His EEG was abnormal: there was bilateral slowing with high voltage on the right side with some delta activity. The serum electrolytes and urea nitrogen were normal, as were the routine urinalysis and complete blood count.

At 27 months of age his weight was 7.7 kg and his head circumference 52 cm (approximately 1.7 S.D. above chronological mean). He had become spastic and somewhat rigid. His electroencephalogram revealed no normal activity and there was random slowing throughout, characterized as a generalized disorder. He died at the age of 38 months.

Results

Total hexosaminidase activity in disrupted leukocytes obtained from venous blood was measured with ρ-nitrophenyl-β-N-acetyl-glucosaminide as substrate, as shown in Figure 2. The proband was found to have 14% of activity of 15 age-matched controls. His mother and father had 50 and 60% of control activity, respectively. The enzyme activity of blood relatives who had less than 60% of normal activity were considered as carriers (Fig. 2). Heat inactivation study at 50° C in blood relatives revealed normal proportion of A and B components of β-hexosaminidase activity. β-Hexosaminidase and other lysosomal activities in brain and liver of the proband obtained at autopsy are shown in Table 1. Examination of brain tissue for G_{M2} ganglioside estimated with the procedure described by Sandhoff and Wässle[6] revealed 12.5-fold increase over five age-matched controls.

Electrophoretic separation of β-N-acetyl-hexosaminidase on cellulose acetate paper according to Hooghwinkel et al.[7] shows absence of 'A' and 'B' component; however, there is a presence of 'C' component. In contrast, in Tay-Sachs disease there is a presence of 'B' component but absence of 'A' and 'C' components (Fig. 3). These observations confirm our diagnosis of Sandhoff's disease based on clinical and laboratory studies.

While the affected child was 1½ years old, the mother became pregnant and, with informed consent,

TABLE 1.
Specific Activities of Lysosomal Glycosidases in Human Liver and Brain Homogenates

	LIVER		BRAIN	
Enzyme	Control**	Proband	Control**	Proband
α-Galactosidase	24.7	38.2	4.6	13.0
β-Galactosidase	367.0	639.0	53.5	81.0
β-N-acetyl galactosaminidase*	385.0	30.0	78.5	9.5
β-N-acetyl glucosaminidase*	2735.0	238.0	594.0	81.0
α-Glucosidase	40.0	57.0	5.9	12.7
β-Glucosidase	55.6	98.0	14.7	100.7
α-Fucosidase	112.0	420.0	17.0	37.0
α-Mannosidase	49.0	223.0	11.3	11.8
β-Xylosidase	7.8	15.7	1.7	3.1

* These enzyme activities are commonly referred to as β-hexosaminidase.
** Average of 7-10 liver samples or 5 brain samples. The activities are expressed as nmoles of substrate hydrolyzed per mg protein per hour. The procedure used for measurement of these activities is described by Patel et al.[8]

amniotic fluids were obtained at about 16 weeks of gestation and the cells cultured. The enzyme activity in cultured amniotic cells from the proband pregnant mother revealed normal values, in the upper range of four controls. These control amniotic cells came from individuals with unrelated diseases and were grown under identical conditions. It is noteworthy that the activity of hexosaminidase was normal both when measured with synthetic substrates and with natural G_{M2}-ganglioside. (The assays with G_{M2}-ganglioside labeled with ^{14}C on N-acetyl-galactosamine moiety were kindly performed by Dr. E. H. Kolodny of Eunice Kennedy Shriver Center for Mental Retardation, Inc., Waltham, Massachusetts.) These studies suggested that the fetus would not be afflicted with Sandhoff's disease; the subsequent development of this child has borne out this prediction.

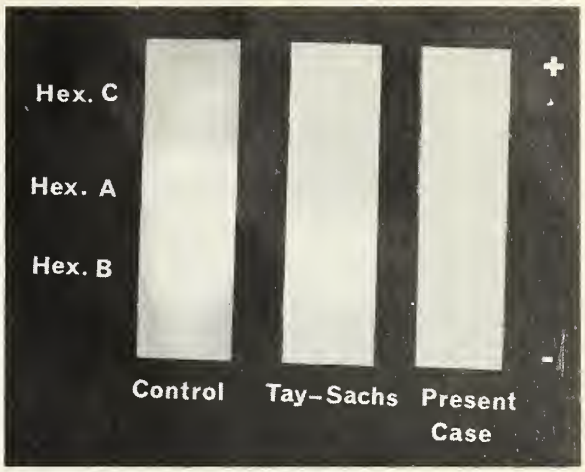
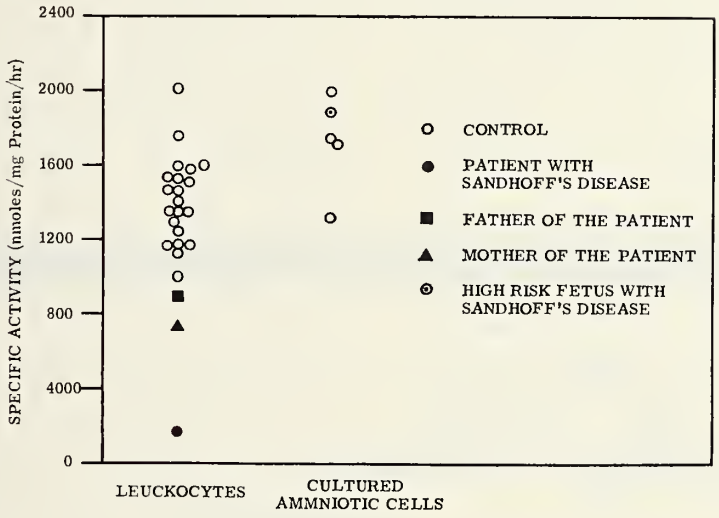


FIGURE 3.
Electrophoretic separation of hexosaminidase of brain extract from present case, Tay-Sachs case and normal control.



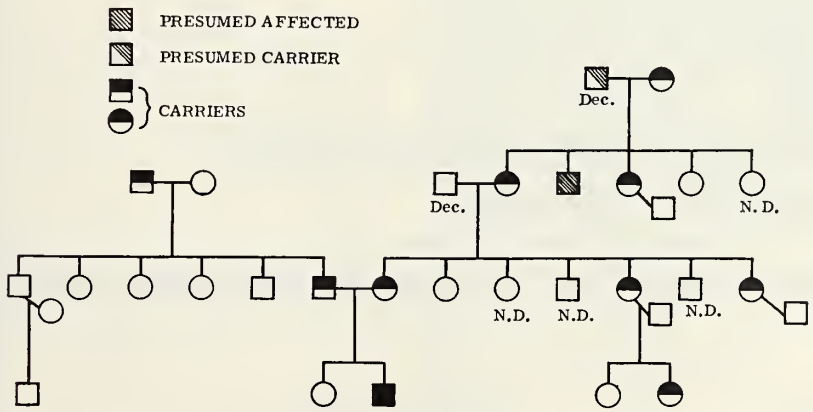


FIGURE 2.
Total hexosaminidase activity in leukocytes and amniotic cells. The activity was measured with *p*-nitrophenyl-β-N-acetyl-glucosaminide as substrate (3 mM) at pH 4.4 in citrate-phosphate buffer (upper part). The lower part of the figure shows the pedigree of the proband. The carriers are those blood relatives whose activity of hexosaminidase is less than 60% of average control activity.

Comment

This study appears to be the first in which it was possible to examine a large number of blood relatives of a patient with proven Sandhoff's disease. Of particular interest is the statement of the proband's great-grandmother that her second child, a boy, had a disease which was in every respect similar to that of the proband. This woman also had a reduction of hexosaminidase activity which put her into the heterozygous group; unfortunately, her husband had died and was not available for study. Nevertheless, the fact that two out of four siblings could be classified as carriers makes it probable that the father of these children was also a heterozygote. Efforts to study blood relatives of this man have been unsuccessful.

Summary

A three-year-old child with Sandhoff's disease is described. The diagnosis was made on the basis of enzyme determinations on peripheral leukocytes. A total of 25 blood relatives of the patient could be studied and heterozygotes were arbitrarily defined as individuals whose enzyme activity did not exceed 60% of normal. The resulting pedigree strongly suggests an autosomal-recessive mode of inheritance and that a paternal granduncle of the proband also had the same disease. The

proband's sister shows normal enzyme activity of her leukocytes; this was predicted on the basis of enzyme determinations on her amniotic cells performed during the 16th week of gestation.

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Patients with congenital hemolytic anemias who require excess folic acid may require excess Vitamin B_{12}.

Subacute Combined System Degeneration in Cooley's Anemia

Excessive Vitamin B_{12} Utilization Producing A Relative Deficiency Combined System Degeneration

ROGER FRANK ROBISON, M.D.
Bloomington

IN patients with chronic hemolytic anemia, especially congenital types, folic acid therapy has been recommended in order to prevent a megaloblastic anemia.[1,2,3] However, little mention has been made of the possible need for supplemental Vitamin B_{12} in chronic hemolytic anemia. The case report to follow describes a patient with Cooley's anemia who had a dramatic improvement with folic acid at 18 years of age but then developed subacute combined system degeneration 5.5 years later. The gastric analysis, Schilling test, and serum B_{12} level were all within normal limits. Over a 12-month period the patient attained a full neurological remission with Vitamin B_{12} therapy.

Case Report

A 23-year-old male graduate student was admitted to the hospital Jan. 4, 1971, because of progressive inability to climb stairs during the preceding three weeks.

At age seven years he was diagnosed as having Cooley's anemia when he was evaluated for a heart murmur and a hemoglobin of 9 g/100 ml. Both parents were found to have thalassemia minor and all four grandparents were born in Italy. A sister is unaffected. Figures 1 and 2 illustrate the dissimilar appearance of the patient and his parents.

The patient was untreated and asymptomatic, except for slow growth and the characteristic skeletal deformities (Figure 2), until age 15 11/12 years. At this age he developed a 6.5% hematocrit reading and thereafter required frequent transfusions.

At age 16 11/12 years a splenectomy was done but he continued to require transfusions every 4 to 6 weeks.

At age 18 he was evaluated at Walter Reed Hospital, where he was noted to be 159 cm (5 ft. 2½ in.) tall and weigh 43 kg (95 lbs.). Hemoglobin electrophoresis revealed an A_2 value of 5.3% and a fetal of 6.9%. He was then started on folic acid therapy (10mg/day) and has not required transfusions since. He experienced the painful "erythropoietic crises" in his long bones and pelvis, as described by Miesch[4] and Jandl and Greenberg,[5] during the first few days of marrow regeneration after starting folic acid therapy.

At the age of 22 he started graduate work at Indiana University and was found to have the following laboratory profile: hematocrit was 30%, hemoglobin was 9.6g/100 ml, leukocytes per MM^3 were 14,700, platelets were 300,000/MM^3, reticulocytes were 9% of red cells, nucleated red cells were 10-20/100 leukocytes, uric acid was 15.6 mg/100 ml, L.D.H. was 450 IU/L,



FIGURE 1
ITALIAN parents of the patient.

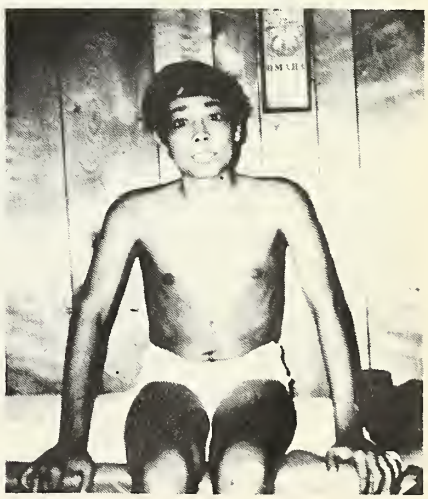


FIGURE 2
PATIENT with Cooley's anemia.

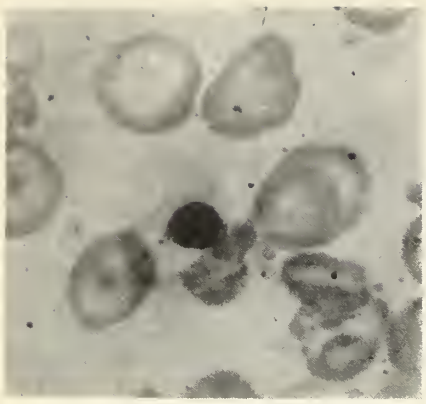


FIGURE 3
PERIPHERAL blood smear showing target cells, nucleated red cells, anisocytosis and poikilocytosis—oil immersion lens.

SGOT was 100 Karmen units/ml, total bilirubin was 5.5 mg/100 ml. The starch block hemoglobin electrophoresis revealed the following: $A_2 = 5.1\%$, $A^1_2 = 0.8\%$, $A = 30.1\%$ and fetal = 64%. Figure 4 illustrates the peripheral blood smear.

When admitted to the hospital at the age of 23, he complained of difficulty in walking downstairs, saying his "feet got tangled up with each other" and had to hold onto the handrail to keep his balance. He could not run or run upstairs without stumbling or tripping. He also had tingling and burning in both legs. Physical examination revealed the characteristic skeletal deformities of Cooley's anemia—a wide stance and a chronic medial malleolus ulcer (Figures 4, 5, 6). He was 171 cm (5 ft. 7½ in.) tall and weighed 54.5 kg (120 lbs.). Cranial nerves, motor system and mental function were all normal. The knee jerk and ankle jerk were hyperactive bilaterally, but the deep tendon reflexes on the upper extremities were normal. Babinski's, Oppenheim's, and Chaddock's signs were all elicited bilaterally. There was diminished-to-absent vibration sense in both lower extremities, more marked on the left. Position sense in the great toes and pain sensation in both legs appeared normal. Romberg's sign was positive. Heel-to-shin coordination was impaired bilaterally but the upper extremities had intact coordination. X-rays of the thoracic and lumbar spine were characteristic for expanded hematopoietic activity. The results of the CBC, platelet count, reticulocyte count, peripheral smear and liver function test were unchanged from the previous year. Gastric analysis and the Schilling test results (5.9% recovery) were within normal limits. Cerebrospinal fluid protein was 286 mg/100 ml with 3 RBC and 5 WBC per MM^3 seen. The bone marrow had a cell/ fat ratio of 100/0; a WBC/RBC ratio of 1:2, and 3+ iron deposits. No maturation arrest or megaloblastic changes were seen. A serum Vitamin B_{12} level was reported by Bio Science Laboratories (Van Nuys, Calif.) as 510 picograms/ml (N = 170-760). Parenteral B_{12} was given at a dose of 100 μg daily for 14 days, then once a month. Improvement occured as noted below.

Jan. 4-5, 1971: Hospital diagnostic studies, including serum B_{12} levels.

Jan. 7, 1971: Schilling test, start B_{12} therapy.

Jan. 12, 1971: No improvement.

Jan. 28, 1971: Right leg: Babinski sign present, deep tendon reflexes and vibration sense almost normal. Left leg: Babinski sign present with hyperactive reflexes; impaired vibration and coordination. Romberg sign positive.

Feb. 18, 1971: Babinski negative on right, positive on left. Vibration sense normal in both legs. Romberg sign negative.

Mar. 19, 1971: Right leg: normal. Left leg: Babinski sign present with hyperactive deep tendon reflexes; heel-to-shin coordination poor. Romberg sign, negative.

Apr. 21, 1971: Bilateral positive Babinski sign but no hyperactive reflexes. Left leg: impaired vibration and heel-shin coordination. Normal gait and stair climbing, but Romberg sign positive.

June 9, 1971: Bilateral positive Babinski sign. Positive Romberg sign.

July 9, 1971: Bilateral positive Babinski sign. Left heel-shin coordination almost normal. Romberg sign negative.

Aug. 6, 1971: Normal except bilateral positive Babinski sign.

Sept. 3, 1971: Left Babinski sign only. Left heel-shin coordination poor.

Jan. 24, 1972: No neurological deficit.

Discussion

Folic acid therapy was introduced for the treatment of megaloblastic anemia in 1945.[6] The danger of masking a B_{12} deficiency and allowing the neurological disease to progress by giving folic acid to a B_{12}-deficient patient has become well known.[7,8,9,10]

It has been recognized since at least 1959[5,11] that patients with chronic hemolytic anemia may require pharmacologic doses of folic acid. The simplest explanation for this requirement is that a bone marrow involved in the rapid production of red blood cells may utilize such excessive amounts of folic acid that a normal diet can not keep pace with the demand. The patient described herein was able to produce enough red cells to balance hemolysis until he reached a delayed puberty at age 15 11/12 years. Excessive doses of folic acid then allowed him



FIGURE 4
FACIES of Cooley's anemia.



FIGURE 5
PATIENT assuming wide stance in order to keep his balance.

to again reach a balance between red blood cell production requirements and chronic hemolysis.

His development of subacute combined system degeneration and its complete remission with parenteral Vitamin B_{12} therapy indicated a Vitamin B_{12} deficiency. This was not coincidental classical Addisonian pernicious anemia, which has previously been reported in hemolytic anemias,[12,13] because there was no evidence of intrinsic factor deficiency. The patient had a normal Schilling test and a normal serum Vitamin B_{12} level. He was eating a regular American diet and was not a vegetarian. Therefore, this patient was assumed to have developed a relative B_{12} deficiency for the same reason that he developed a folic acid deficiency—excessive utilization.

This patient had a full neurological recovery in spite of the fact that he had developed a bilaterally positive Babinski sign. This latter finding has been reported[10] to indicate the likelihood of an incomplete resolution of the neurological deficit.

The survival of patients with severe congenital hemoglobin disorders is improving, due to better supportive care and improved concepts such as adjunctive folic acid therapy. It would seem advisable to do periodic neurological testing in chronic hemolytic anemia patients who require excess folic acid. Whereas subacute combined system degeneration may be a rare occurrence in these patients, the neurological deficit may be very slow in leaving or may become permanent.[14]

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FIGURE 6
POSITIVE Chaddock's sign seen with lateral column (pyramidal tract) disease.

THIS statement, taken from the Bulletin of the American College of Radiology, is published here for the information of all practitioners.

ACR Statement on Mammographic Examinations

THE ACR Commission on Cancer and its Committee on Mammography and Diseases of the Breast have prepared a statement on the conduct of mammographic examinations. The new policy, which was approved by the Board of Chancellors at its June meeting, is as follows.

I. Introduction

Mammography has proven to be the most effective diagnostic tool so far developed for the detection of breast cancer at an early stage before it spreads to regional lymph nodes. This early detection increases the probability of cure. Mammography at appropriate intervals in asymptomatic women over age 35 promises to reduce significantly the number of deaths from breast cancer.

Since there is now no definitive scientific evidence with regard to:

1. optimal age for the initial mammogram;
2. frequency of examination;
3. data on possible long term radiation risk;

this statement is being issued, as a summary of current informed opinion.

II. Care of Women with Symptoms

In women who have symptoms or physical findings suggestive of possible breast cancer, medical decisions must be individualized to fit the patient's needs. Under these circumstances, mammography is an integral part of the evaluation of the patient.

III. Screening of Asymptomatic Women

Recognizing that definitive data are not yet available that allow the establishment of firm criteria that define a protocol for the screening for breast cancer in asymptomatic women, the ACR recommends the following:

1. All women should have annual physical examination of the breast and be taught breast self-examination.
2. For asymptomatic women the first, or baseline, mammographic examination should be performed between the ages of 35 and 40.
3. Subsequent mammographic examinations should be performed at one to three year intervals unless more frequent examination is medically warranted.
4. After age 50, annual or other regular interval examinations, including mammography, should be performed.
5. Although the carcinogenic effects of radiation at current levels of exposure are probably immeasurably small, continuing attempts to reduce exposure should be made. However, image quality must be preserved for accurate diagnosis to insure the best risk/benefit (cure) ratio.
6. Each radiologist should assure the periodic monitoring of his equipment and procedures to determine that the patient's exposure is being maintained at the lowest feasible level.

IV. Research Programs

The protocol currently being followed by the NCI/ACS sponsored "Breast Cancer Detection Demonstration Projects" should be pursued so that the data are as complete and accurate as possible in order that meaningful conclusions can be drawn. Follow-up of the patients must be carried out for a number of years to insure collection and evaluation of the data. Theoretical concerns of possible radiation-induced breast cancer do not warrant change in the current protocol of the "Breast Cancer Detection Demonstration Projects." Estimates of risk that include a radiation carcinogenic effect are of dubious validity because of the lack of objective scientific evidence. Research must be continued and encouraged to:

1. improve methods for measurement of low level radiation;
2. further reduce the radiation dose in mammography consistent with good image quality;
3. determine the most appropriate age at which to begin screening for different risk groups;
4. define women of high risk;
5. define those mammographic findings that dictate re-examination at a shorter interval;
6. establish the appropriate intervals for re-examination; and
7. collect evidence of the benefits and risks of mammography.

V. Future Statements

Further statements will be issued when additional valid information permits.—**Bulletin of the American College of Radiology, August 1976.**



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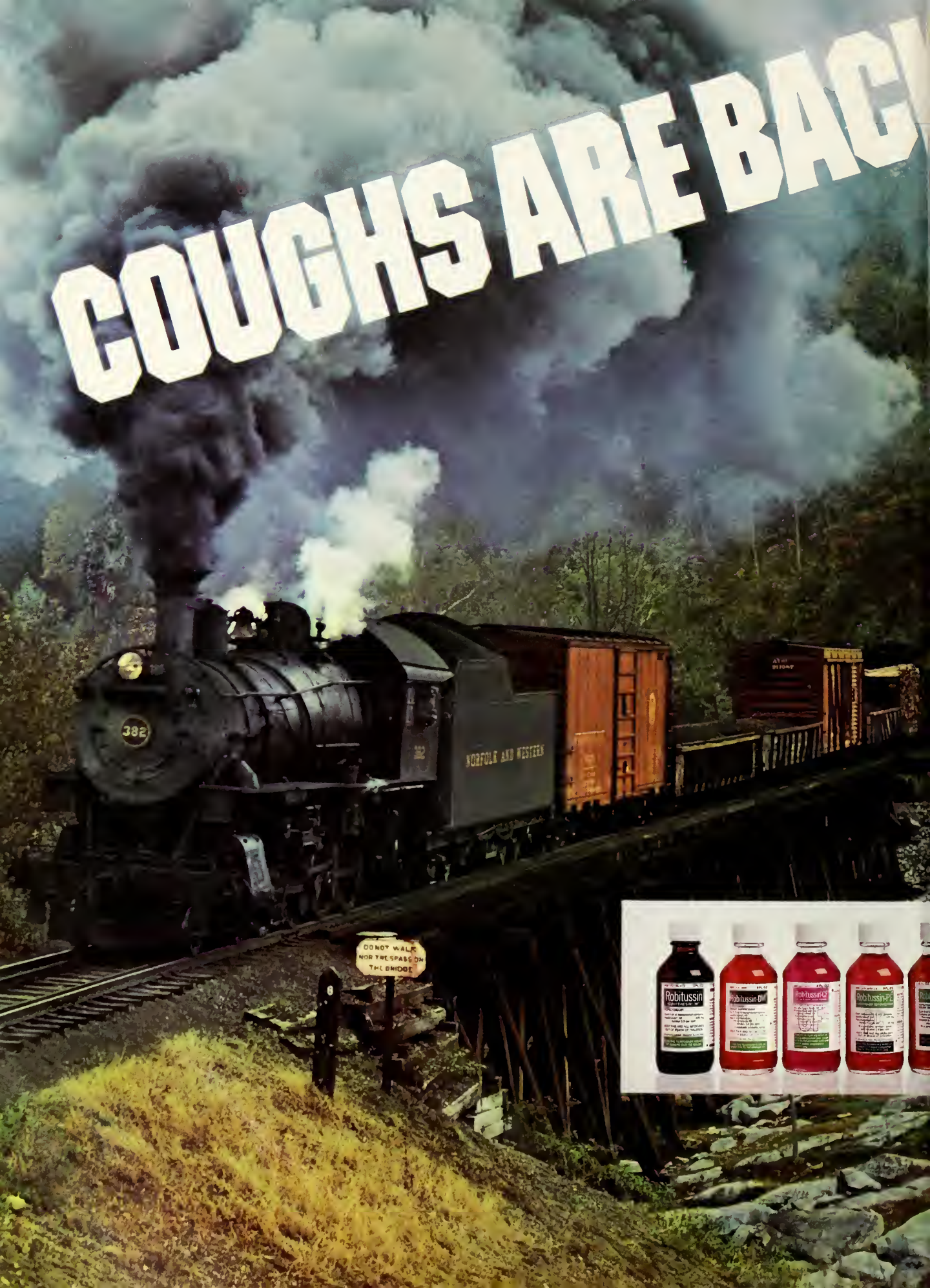
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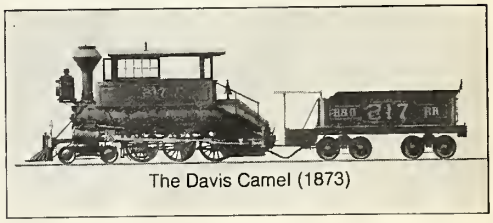
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Clinical Comparison of Iocetamic Acid, Iopanoic Acid and Tyropanoate Sodium

T. R. MARSHALL, M.D.
Louisville, Ky.

THE cholecystogram is one of the most commonly used and respected radiological examinations. It has been estimated that approximately 15 million people in the United States have cholelithiasis, incuding as least 20% of the population 50 years of age or older, and approximately one million new cases occur each year.[1] There are many conflicting reports on gallbladder contrast media in regard to density produced, major and minor side effects and diagnostic results.

The degree of visualization and radiological density of the gallbladder are the important factors in detecting whether stones are present radiologically. Tolerance of the contrast medium and side effects are extremely important clinical facts to consider. The ideal contrast medium is one that produces the best visualization and density to show stones or other filling defects and has fewer major and minor side effects. This study was undertaken on a clinical basis in routine radiological patients undergoing gallbladder examination. Standard doses as recommended by the manufacturer were employed.

One hundred fifty patients who presented themselves for cholecystography with symptoms of gallbladder disease were examined and divided into three groups, each group of 50 receiving either iocetamic acid (Cholebrine) 3.0g(4x750 mg tabs), iopanoic acid (Telepaque) 3.0g(6x500 mg tabs) and tyropanoate sodium (Bilopaque) 3.0g(4x750 mg capsules). All patients received the contrast medium at 7 p.m. after a fat-free evening meal. Nothing but water until midnight was permitted prior to the examination. Which patient received which drugs was not known until the analysis of the radiographs was complete. Those patients with nonvisualization or poor visualization on the first study were given a repeat examination using the same drug with the same dosage. The second dose was given at 7 p.m. on the day of the initial cholecystography after a fat-free supper. A fat-free diet was continued for all of the meals prior to the second radiological examination. The next morning standard prone and oblique radiographs plus erect spot-films were obtained.

A blind crossover study giving the three agents to the same patient at different times would be the preferred method but almost impossible to do under present clinical practice. Therefore, routine patients with gallbladder symptoms were chosen for study. Density and visibility of the gallbladder shadow are of prime importance in the demonstration or exclusion of stones. Many factors such as liver function, bile duct patency, intestinal absorption, patient size, and technical factors can influence the density. Non-visualization in chronic cholecystitis is generally thought to be due to the inability of the inflamed gallbladder mucosa to absorb and concentrate water. Lasser[2] has stated

TABLE 1

Side Effects—150 Patients

	CHOLEBRINE (Iocetamic Acid 3.0 g)	TELEPAQUE (Iopanoic Acid 3.0 g)	BILOPAQUE (Tyropanoate Acid 3.0 g)
Fainting	2%	2%	4%
Nausea and Vomiting	2%	4%	4%
Nausea	4%	10%	8%
Dizziness	5%	15%	12%
Diarrhea	4%	16%	6%
Dysuria	0%	6%	2%
Abdominal Pain	0%	4%	2%
Headache	10%	16%	10%
Hives	0%	2%	10%
Number of Patients	50	50	50

Dr. Marshall is associate clinical professor of radiology, University of Kentucky School of Medicine, Lexington, and practices at the Orange County Hospital, Paoli, Ind. 47454, and in Louisville.

TABLE 2

Density of Gallbladder Capacity

	EXCELLENT	GOOD	FAIR	POOR	NONE
Iocetamic Acid Cholebrine 3.0 g	40%	38%	6%	8%	8%
Iopanoic Acid Telepaque 3.0 g	30%	38%	10%	10%	12%
Tyropanoate Sodium Bilopaque 3.0 g	30%	40%	9%	11%	10%

TABLE 4

Number of Diagnostic First-Day Studies

Iocetamic Acid Cholebrine 3.0g	78%
Iopanoic Acid Telepaque 3.0g	68%
Tyropanoate Sodium 3.0g	70%

that nonvisualization is caused by diffusion of the contrast media through the diseased mucosa of the gallbladder and into the bloodstream.

The radiographic procedure was standardized and all films were of good radiological quality. Patients in the iocetamic acid (Cholebrine) group had a lower incidence of fainting, nausea and vomiting, nausea, dizziness, diarrhea, dysuria, abdominal pain, headache and hives (Table 1). Density or opacity of the gallbladder was excellent in 40% of the patients given iocetamic acid, 30% in the patients given iopanoic acid, and 30% of the patients given tyropanoate sodium (Table 2). Visualization was excellent or good in 78% of the patients given iocetamic acid, 68% of the patients given iopanoic acid, and 70% in the patients given tyropanoate sodium. In 78% of the patients receiving iocetamic acid, diagnostic studies were obtained on the first day (Table 4).

TABLE 3

Repeat Dose Required Because Of Non-Visualization Or Fair-To-Poor Visualization

	NO. EXAMINED	REPEAT DOSE	NO. THAT DID NOT VISUALIZE ON REPEAT
Iocetamic Acid Cholebrine 3.0g	50	14%	8%
Iopanoic Acid Telepaque 3.0g	50	20%	12%
Tyropanoate Sodium Tilopaque 3.0g	50	20%	10%

Conclusions

The number of patients reporting abdominal pain, nausea, and nausea and vomiting and diarrhea was lower in the iocetamic acid (Cholebrine) group than in the iopanoic acid (Telepaque) and tyropanoate sodium (Bilopaque) groups. Density of visualization was better in the iocetamic acid (Cholebrine) group on the first examination and the number requiring repeat examinations was also lower.

Summary

A study was undertaken to determine the best gallbladder contrast medium for use in routine clinical practice. Comparison of Cholebrine, Telepaque, and Bilopaque showed that the Cholebrine was superior to the other two agents.

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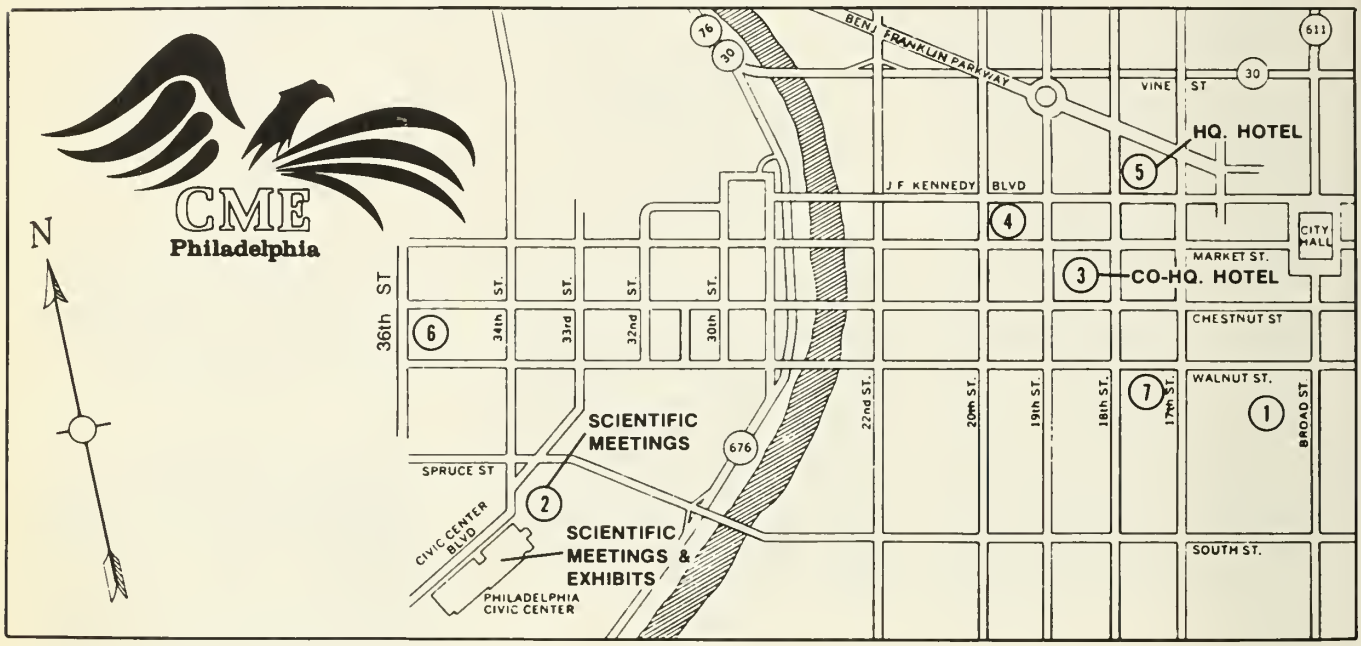
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A Brash, Bold Bid!

ARNOLD LIEBERMAN, M.D.
New York City

TO claim a *First* for anything clinical bespeaks usually a sloppy survey of the literature. Yet Jacobeus van Arlen was unorthodox from first to last! When he entered this world before the turn of the century the attending physician tagged him with the label of a rare disorder and told his parents that he would not survive much beyond infancy. The passing years disproved that diagnosis most emphatically.

Jacobeus had an artistic bent and trained himself as a sculptor with a special interest in picture framing. He did well. He was married very late; many years later, his wife bore them a baby boy. This was 1939.

Saved by Dutch Underground

The Nazis struck with such lightning speed that Holland was occupied before they could flee. After they had spent only a few months in a concentration camp, the Dutch Underground had the startling luck of smuggling the *entire* family out through Denmark and over to Sweden! There may have been similar cases but my contacts answer an unequivocal *NO*. The family went on to England and then—after the end of the war—the still-intact family unit arrived in the promised land: NYC in the USA.

Jacobeus (or Jack as he came to be called) resumed his artistic career and flourished, professionally and personally. It was 1961 when he was referred to me by a G.P. for treatment of the abdominal angina that had begun to develop. He was 65 years old; a rather tall, lean chain smoker who consumed three to four packs of cigarettes daily. The physical findings were unrevealing; the E.K.G.s, chest films, lab. studies, etc. were within normal limits; the cholesterol was *under* 200. A very faint, pre-systolic murmur was dismissed as "most probably" innocent. His past history was one of rugged health: an occasional URI and such.

He was given the usual medications and advice. The smoking was reduced to "only" a pack a day. He did use a filter and a cigarette holder. He was adamant about not reducing his heavy stint at the shop, even though his son was willing and able to step into the breach. The anginal symptoms disappeared. His wife (very devoted and intelligent) did tell me that the nitroglycerine was always within reach, "just in case." Their family physician moved out of town and they started coming to me.

In 1963 the angina recurred. Rather grudgingly, he consented to take a vacation trip to Holland where he and his wife stayed for two months; the son stayed here in New York City taking care of the business. It was the next year that there was an exacerbation of symptoms. He was placed in a hospital and given an extensive work-up, plus the benefit of several consultations. His B.P. of 170/85 dropped readily back to normal. The murmur became all but inaudible; the cholesterol still hovered around 200; the E.K.G.s and E.E.G.s were read as "within normal limits"; an I.Q. was somewhat over 100.

The story now was becoming repetitive. The eyegrounds began to reveal an increasing arteriolosclerotic pattern. He took his nitroglycerine almost daily—sometimes twice and even thrice. He was obdurate about working as hard as ever. By 1966, intermittent claudication began to plague him: the peripheral pulses were fading away, slowly but unmistakably. Also, the uric acid began to rise; allopurinol to the contrary, gout began to gnaw away at some of his joints. The toes were not affected, but I had to aspirate the deltoid bursae as well as the knee joints. Most grudgingly, Mr. van Arlen consented to taking yearly boat trips to Holland, vacationing there for lengthening weeks and even months.

In 1968 he had his first obvious bout of heart disease. There was a late evening call: Mr. van Arlen had had a sudden burst of atrial fibrillation with PVCs for emphasis. An ambulance took him to a hospital, where he received the works. When the heart rate returned to normal, he signed himself out—no one could keep him away from his beloved shop. His shelf-full of medications he did consume: his wife saw to that.

In the course of events, the son had married a girl from New Orleans. The family began to give serious consideration to picking up and moving to that city—lock, stock and barrel. While on a trip there, he went to see a local physician who prescribed for him a "picker-upper": Ritalin on arising and again at noon (if needed).

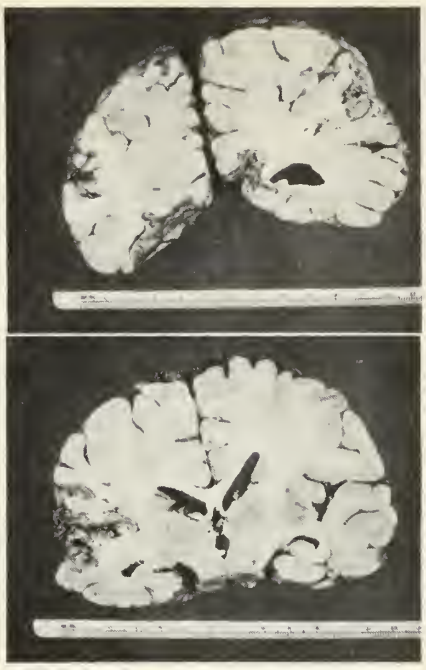
At 76: Vertical Hemianopsia

By 1970, he was still here in New York, struggling with the developing CHF, exacerbating gout (never mind the Xyloprim, Benemid, etc.), and a latent diabetes. Of course, by now he was 76 years old, thus seeming to bear out his frequent reiteration, "We Dutch are tough—never mind what the doctors think." Still—in October of that year—we come, finally, to the UNUSUAL! While on a visit to New Orleans he experienced a sudden attack of *ver-*

tical hemianopsia attended with some mental confusion. An E.E.G. taken there reported, "some abnormal delta waves over the occipital lobe." Recovery was rapid: in only 10 days' time he seemed his normal self. When I saw him back in New York City, he looked as if there had been no intervening problem. Although still refusing hospitalization, he did agree to cut his working to half time.

During the period of 1970-72, our friend had no less than EIGHT bouts of T.I.C.A. (medical shorthand for "transient ischemic cerebral attacks.") Every text book has detailed descriptions of this type of vasospasm. Without belaboring the point, one should merely insert the reminder that the brain is the only tissue that cannot be deprived of its blood supply for more than just a few minutes; if the spasm is not relieved, infarction of the bloodless cells occurs. In our patient, it was clear that the damage was localized to the branches of the left cerebral artery. Only once did the right cerebral artery misbehave. The affected vessel is usually some terminal branch of the middle cerebral artery. Our patient had had repeated exhaustive studies during and after each attack. Each T.I.C.A. seemed to clear as swiftly as it came. All parameters after each bout were pronounced as "within normal limits." The consultants performed cerebral arteriographies, spinal taps, repeated E.E.G.s, scans: everything NORMAL! In hindsight, there is an eerie unreality about it all. There was *never* a mental deficit.

In the summer of 1972, while on a ship returning from Holland, there was another such bout. I'm looking at the letter addressed to me by the ship surgeon: "Recovery complete before docking at NYC." Still, enough is enough. After prolonged consultations he was heparinized and placed on just sufficient coumadin to keep the Lee-White about two-to-three-times normal. His mentation remained excellent in spite of the known, extensive AS plaques in the left internal carotid and middle cerebral arteries. The E.E.Gs were



definite in pinpointing the vasospasms to the left parietal and occipital lobes with a question as to the right side.

We now come to the ELEVENTH documented episode. In December 1972 he had another sudden loss of speech and right-sided weakness. In the hospital, there was a continuing deterioration of affect and cognition. For the very first time, he needed restraints and I.V. feedings. This went on for several days. And then—quite dramatically—just when hope was fading—he began yet another comeback. First, he babbled; then, there was sensible speech. He sat up in a chair and cracked the never-to-be-forgotten, Krentenweger joke.

"You know, Dr. L., we Dutch are very thrifty; some call us parsimonious. When a real miser buys berries (krenten), he does not simply buy them by the box: he actually *counts* them. In Dutch, we call them 'krentenwegers.' "

The attendings were unanimous in agreeing on the continuation of the anticoagulants. Some pulmonary consolidation was treated with the usual antibiotics, O_2 and such. He was taken off critical. The wife and son were consulted at length re a possible discharge to a nursing home, rather than to his own apartment. The resident and I were more than a little startled by the wife's sad interjection, "All this discussion, I fear, is fruitless. I *know* in my bones that Jack will not leave the hospital alive. Please don't let him suffer!" In the light of later events—what gave her such prescience?

On New Year's Day he was sitting in a bedside chair eating all by himself. The resident went by and they exchanged some small pleasantries. A few minutes later, the aide helped Mr. van Arlen back into bed. He noticed nothing wrong. Five minutes later, the nurse walked in for the usual: the patient was slumped in bed: DEAD! All attempts at resuscitation were futile.

The autopsy on this 78-year-old man was meticulous. The heart had an ancient, well-healed anterior wall infarct. As expected, all the arteries had extensive plaques—low cholesterol or no low cholesterol. The lungs showed some slight patches of early bronchopneumonia. The brain startled us. In the cortex there were "organizing, temporoparietal and occipital lobe multiple infarcts." Microscopically, "Temporoparietal region on the left side has depressed and soft areas." Serial coronal sections display yellowish areas about 3.5 cm in diameter; they show "rarefaction and marked astrocytosis (gemistocytic)." In G.P. language, tumors formed by the destruction of neurons as a result of the repeated severe hypoxic episodes.

We had started the patient on coumadin and heparin for the precise purpose of preventing just this clotting. So what was the pathological basis of the disaster? To compound confusion of the clinicians, the pathologist at the hospital went on to state flatly: "The multiple cerebral infarcts *occurred at about the same time!* . . . I am at a loss in explaining the asymptomatic intervals between the T.I.C.A."

It was really an unequivocal finding but—just to make assurance doubly sure—I took the serial sections to the chief pathologists at a couple of famous institutions on

whose staffs I happen to be. Their quick and emphatic agreement with the other pathologists and neurologists could not be more dogmatic! Our enigmatic patient at no time had even a clinical hint of organic dementia or any schizophrenic tendencies.* Granted that the frontal lobes were not involved; still? His artistic artisanship, his zest for life, his *total* clinical recovery after each vasospasm—how is it that we all failed to see the slightest aberration? "Gemistocytic" indeed! And—to crown the incredible—ALL the involved arteries clotting simultaneously! A diligent search of the texts and the literature has yielded to me and my cohorts a total blank. The WHY'S are a never-ending chain, "a puzzlement." Can *you* come up with an idea?

1270 Fifth Ave., No II-R
New York 10022

*Regional Cerebral Blood Flow in Organic Dementia and in Chronic Schizophrenia, *Triangle, Sandoz Journal of Medical Science*, Vol. 13, #1, 1974, pp. 17-23. Professor D. H. Ingvar, Lund, Sweden.

Notice to Indiana Physicians

Clinical research is in progress at the Indiana University School of Dentistry in the bleaching of tetracycline stained teeth, discolored teeth affected with fluorosis and other causes of tooth discoloration.

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Guest Editorial

Whatever Happened to Self-Reliance?

"GOVERNMENT," as former Senator Sam Ervin said, "is a parasite." No group of men was ever more aware of the truth of that statement than our Founding Fathers. The Revolution was fought to escape one oppressive government; the Constitution and the Bill of Rights were carefully drafted to forestall our falling victim to another.

The operative premise in those earlier days was that free people could take care of themselves if government was *prevented* from interfering.

Today, we are standing that philosophy on its head. Many are no longer willing to accept personal responsibility for their own well-being. Our individual failings are attributed to the actions of others. "Society" is blamed, or "these troubled times."

We speak carelessly of a proliferation of new "rights": The right to food, housing, medical care, income, employment. And not just "employment," but "meaningful" employment at a "decent" wage.

But speaking of a "right" to economic goods and services creates a dangerous illusion, an illusion that these things are a part of our natural endowment. They are not.

Before food can be eaten, it must be grown; before housing can be occupied, it must be built; before wealth can be "redistributed," it must be created. These things do not happen by accident, Divine intervention, or act of Congress. They happen because people make individual decisions to risk their effort, their capital, or both, to produce something.

A society that denies its producers the rewards earned by their initiative and responsibility hazards both moral and fiscal bankruptcy. The producers will stop producing, and there will be little left to transfer to the nonproductive.

Thomas Jefferson made plain his own priority of economic rights in 1816. It's worth reviewing now.

"To take from one," he wrote, "because it is thought that his own industry and that of his father's has acquired too much, in order to spare to others, who, or whose fathers have not exercised equal industry and skill, is to violate arbitrarily the first principle of association—the *guarantee* to every one of a free exercise of his industry, and the fruits acquired by it." (Emphasis Jefferson's) — **Richard L. Lesher, president, Chamber of Commerce of the United States, Washington, D.C.**

Editorial Notes . . .

The new rules which require a hospital to arrange a 48-hour review for each admission to maintain JCAH accreditation and a 72-hour review to qualify for reimbursement for Medicare/Medicaid patients are making computer-taken and computer-recorded medical histories more and more attractive. The patient is provided with an extensive list of questions arranged with branching logic so only pertinent questions are answered. The "yes/no" question format is marked with pencil. The computer then digests the data, arranges them in standard format and produces a print-out at the hospital. This system can also include pertinent negative responses. The result is a highly standardized medical history which, in the case of most clinicians, will have to be supplemented by direct interview and added longhand entries, but will, at inordinate expense, fulfill the demands of the HEW and the JCAH.

The rising cost of malpractice insurance for hospitals is drastic enough to require the raising of room rates for this one cost item alone. For all hospitals the average increase was $4.65 per day. In a few instances the raise has been as high as $25 a day.

Prostaglandin researchers at Upjohn report the synthesis of long-acting antithrombotic agents based on prostaglandins. Possible applications to be investigated are prevention of postoperative thromboembolism, protection of patients after coronary bypasses and lessening of

the risk of stroke or coronary thrombosis in susceptible patients.

Metropolitan Life reports an increase in deaths among riders of pedal cycles from 2.8 per million population in 1960 to 4.7 in 1974. Whether the increase is due to more cycling or more dangerous circumstances makes no difference. Safety in cycling should be stressed. The death rates per million population for age brackets are: 5 to 9—10.9; 10 to 14—15.8; and 15-19—10.1. All other age brackets are under 3.1. This also reflects who does the most cycling as well as who is less experienced and possibly less careful.



"IS IT CONTAGIOUS, DOCTOR?"

The VA is conducting research on energy conservation. One hospital, a nursing home and a research lab are now testing solar panels, heat pumps and a device which will utilize excess energy in the summer to manufacture ice to be stored underground for cooling the next summer. The research lab has a solar panel system to provide heating and cooling systems and is connected to the VA Washington Headquarters computer in order to determine which of 30 methods of air conditioning will be most efficient.

Serious adverse drug reactions have been greatly exaggerated. Most of those reported in the daily press have occurred in patients who were in the process of dying from basic pathology and in whom drug reactions were not significant. Research studies by the Armed Forces Institute of Pathology are reported in an editorial in *JAMA*, to the effect that, of 827 autopsied cases of adverse drug reactions, only 25 were found that might have been prevented. ◄

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BOOK REVIEWS

MODERN HOME DICTIONARY OF MEDICAL WORDS

Morris Fishbein, M.D., Doubleday & Co., Inc., Garden City, N.Y., 1976; 267 pages $1.95.

Dr. Fishbein is a medical writer of renown and this paperback book is aimed at the general public so that the multitudinous array of medicalese with which the media and we doctors assail people may be deciphered. It is a medical dictionary and seems to be a very good one as far as it goes.

The first section comprises more than four-fifths of the book and defines medical lingo, while part two concerns definitions of laboratory tests. I like this last best because the author has modern information succinetly described in terms a layman can understand. Even as a practicing physician it is informative to see a paragraph such, let us say, as on page 248 on "Serum Copper." He says it is necessary for metabolism, increased in anemia, leukemia, lupus, arthritis, rheumatic fever and thyroid dysfunction. It is decreased in renal disease, anemias if iron deficiency, malnutrition and Wilson's disease. Then he defines Wilson's disease. All this is done in three small paragraphs and there are numerous such definitions in this volume.

Taken as a whole, it is a fine effort by an eminent medical editor to collate popular medical knowledge and can be read and consulted by the public and indeed also the profession with intellectual gain.

RODNEY A. MANNION, M.D.
LaPorte

HANDBOOK OF CHEMISTRY AND PHYSICS, 57TH EDITION

Robert C. Weast, Ph.D., editor, CRC Press, Cleveland, 1976; 2,365 pages; $29.95.

The CRC 57th Edition of a Handbook of Chemistry and Physics, as usual, is filled with useful tables, mathematical and chemical formulas. Included are sections of physical properties of matter, general chemical tables and electricity and magnetism from nuclear spin to spark gap voltage. A section on light covers such subjects as photometric standards, emission spectra and refraction indices of organic compounds. This edition comprises 2,300 pages of graphs, data and property information. It serves as a fingertip reference source for anyone involved in any discipline of science.

Tables revised for the new edition include: Illustrative List of Substituted Prefixes; Volume Properties of Water at 1 Atm.; Strength of Chemical Bonds; National Standard Reference Data Systems Publications; and Isothermal Compressibility of Liquids. The successful index introduced in the 56th Edition is continued.

The Handbook is a must for all involved in clinical chemistry, diagnostic nuclear medicine or other fields of laboratory medicine.

LEE N. FOSTER, M.D.
Indianapolis

CURRENT PEDIATRIC DIAGNOSIS AND TREATMENT (4TH EDITION)

C. Henry Kempe, M.D.; Henry K. Silver, M.D.; Donough O'Brien, M.D., Lange Medical Publications, Los Altos, Ca., 1976; $15.00.

Current Pediatric Diagnosis and Treatment is kept *current* by frequent revisions. The 4th edition, releasd in 1976, was preceded by editions in 1970, 1972 and 1974. The authors have tried to emphasize "what is more common and more important, but to include also what is uncommon though still important." The product of their efforts is a succinct, yet comprehensive, textbook of pediatrics.

One of the remarkable traits of this book is the fact that it is almost entirely written by members of the Department of Pediatrics, University of Colorado School of Medicine. Only a superb pediatrics department could accomplish this.

The text runs the gamut of clinical pediatrics. It does not abound in illustrations, but those it does include are pertinent and useful. The plastic cover is practical and the price of $15 remarkably modest. I recommend this excellent textbook for all physicians who see children.

W. D. SNIVELY, JR., M.D.
Evansville

CARDIOVASCULAR PHYSIOLOGY II — INTERNATIONAL REVIEW OF PHYSIOLOGY, VOL. 9

Arthur C. Guyton and Allen W. Cowley, Jr., editors, University Park Press, Baltimore, 1976; 392 pages with tables, diagrams and photomicrograms; exhaustive bibliography; eight chapters, each written by experts in the specific subspecialty.

It is with ever-increasing anticipation that I pick up volumes

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edited under the overall supervision of Professor A. C. Guyton of the University of Mississippi. Over the last decade or two, he has risen (on sheer merit), to the very forefront of physiologists authoring textbooks in that field.

He surely fulfills even the highest of expectations! With brisk conciseness, he gives the reader the expected. This is a text geared to the medical student, the G.P., or even the physiology instructor. Eschewing verbosity, he is clear, concise and to the point. He steadily enhances his eminence in the profession.

The paper, printing and binding are up to their usual high standards. Congratulations all around!

ARNOLD LIEBERMAN, M.D.
New York City

HOME CANNING—THE LAST WORD

Louise W. Hamilton, Gerald D. Kuhn, Ph.D.; Karen A. Rugh, Doubleday and Company, Inc., Garden City, N.Y., 1976; $2.95.

Three authors and the Food Editors of "Farm Journal" have collaborated in producing *Home Canning — The Last Word.* Intended both for the experienced canner and the neophyte, the book includes instructions for canning common fruits, vegetables and meats, along with information on how and why to use certain equipment. The book outlines completely specific rules relating to cleanliness and heat sterilization. Chapter titles cover the benefits of home canning, achievement of safety, canning equipment, canning acid foods in a boiling water canner and low-acid foods in a pressure canner. An easy reference chart and a glossary add to the value of this useful little manual. It contains pertinent line drawings, is paperbound, and sell for $2.95.

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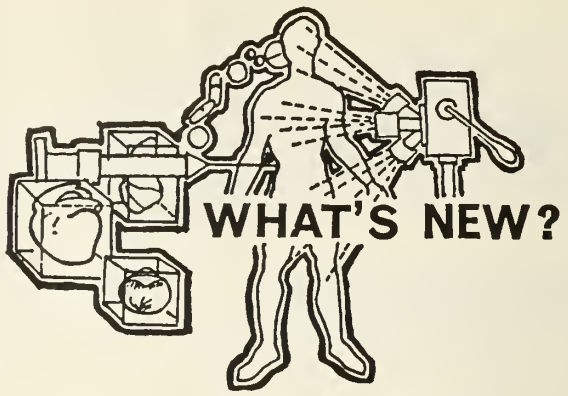
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Upjohn announces an updated package insert for Motrin®, the nonsteroidal, anti-arthritis agent, to reflect clinical experience in the treatment of an estimated 5 million arthritis patients. The sections on clinical pharmacology, indications, warnings, adverse reactions and overdosages are modified.

* * *

Holo Industries are introducing a new lift-transporter which permits paraplegics, invalids and other handicapped individuals to be lifted by an electric lift from their bed to wheelchair and vice versa. It is motorized for both vertical and horizontal movement and has a control panel which the patient may operate.

* * *

The Medtronic Learning Center has a new catalog which lists the firm's array of available educational materials on cardiac pacing. These include books, brochures, videotapes, audiotapes, films and slides, many of which are available without charge.

* * *

Norcliff Thayer, Inc. has an educational device to aid in combating the head lice and scabies problem in school children. Both diseases are increasing. A sound filmstrip educates children about lice—how to avoid, how to diagnose and how to get rid of. Comes with records or cassettes for $6.00.

* * *

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Danal Laboratories announces a new line of ostomy appliances which feature a new plastic, Crixiline®, which is said to have advantages over both karaya, commonly used in rings, and pectin, commonly used for adhesive squares. The new ostomy line will include appliances for small bowel, colon or urinary tract ostomies.

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News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

Arm-Forearm and Thigh-Leg

WE'RE taught in anatomy that the proper terms for the parts of the body that come off the sides of the trunk are the limbs, members or extremities. The upper limbs are divided into arms, forearms and hands. The lower limbs are divided into thighs, legs and feet.

But you would never believe that this prior teaching took place if you saw the way most physicians and the people that follow their direction describe anatomical parts of the limbs and order x-rays of them.

Look through the requests in your x-ray department, and you'll find a request for "the lower arm" when the forearm is to be examined. Or you'll find a request for "the upper leg" when the femur or thigh is to be examined.

The confusion is usually resolved by x-raying the part that hurts, even though that is not following the direction as given by the requesting physician or his aide. The order has to be disregarded as to the part it designates, for the wrong part of the limb is often designated. It's an awkward situation. And in these days of increasing malpractice suits, one wonders who would be at fault, were a suit to develop out of the misuse of basic anatomic terms.

Many attending physicians don't realize that when they ask for an x-ray study of "the lower arm," they're asking for the distal part of the arm—that part just above the elbow. And when they ask for "the upper leg," they're asking for an x-ray of the proximal leg, the part just below the knee.

You'd think this problem would have vanished long ago, because of the efforts of anatomists. But somehow the newly trained physician, who is freshly filled with the proper nomenclature, loses his proper sense for the parts of the limbs and goes along with the current of improper use that his older colleagues are using. And so no dent is made in this bad practice.

I don't know what the answer is to this problem. Do you? ◄



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THIS year, on the occasion of the 100th anniversary of Eli Lilly and Company, Mr. Eli Lilly, honorary chairman of the Board of Directors, delivered a personal commentary on the business. The following are highlights from his observations.

"The year 1876 was not a good time to start a business. Credit was in short supply and bankruptcies were common as the country suffered through a long, postwar depression. Patent medicines had become big business and were often sold by pitchmen as a cure for everything from epilepsy and smallpox to gout and indigestion. Ethical drugs for use by the physician were the smaller and less lucrative part of the market.

"My grandfather, whose name I bear, chose to serve the physician with products of the highest quality. That initial decision continues as our central objective even today. Colonel Eli Lilly was a trained pharmacist and a proven soldier who believed in honesty, hard work and the inherent ability of man to perfect both himself and all his works. His values are equally relevant today, since without them no real progress would be possible.

"Colonel Lilly began his new company with three employees and a total investment of $1,400. He doubled as production superintendent and traveling salesman. After hiring the company's first full-time salesman in 1878, however, the Colonel devoted himself exclusively to on-the-scene management in Indianapolis. Precise compounding of quality products was both his forte and his consuming interest.

"My father, Josiah K. Lilly, Sr., established our first scientific department in 1886 and steadily expanded our drug research program and made science the guide for both our manufacturing and our product evaluations.

"I joined the company officially in 1907, although I had been involved as a part-time bottle washer and dirty-jobs specialist since age 10. My first work after college was as a roving commissioner of efficiency. There was enormous room for improvement, so I couldn't help but succeed.

"Events, at certain times, have a confluence that seems almost preordained. This was the case with the development of our company and the 1921 discovery of insulin by Banting and Best at the University of Toronto. It was as if we had rushed ourselves to a point of readiness just to participate in this momentous event. We offered Banting the full resources of our laboratories to develop large-scale production methods for insulin and thereafter the two institutions worked jointly on the problems of purification and mass production.

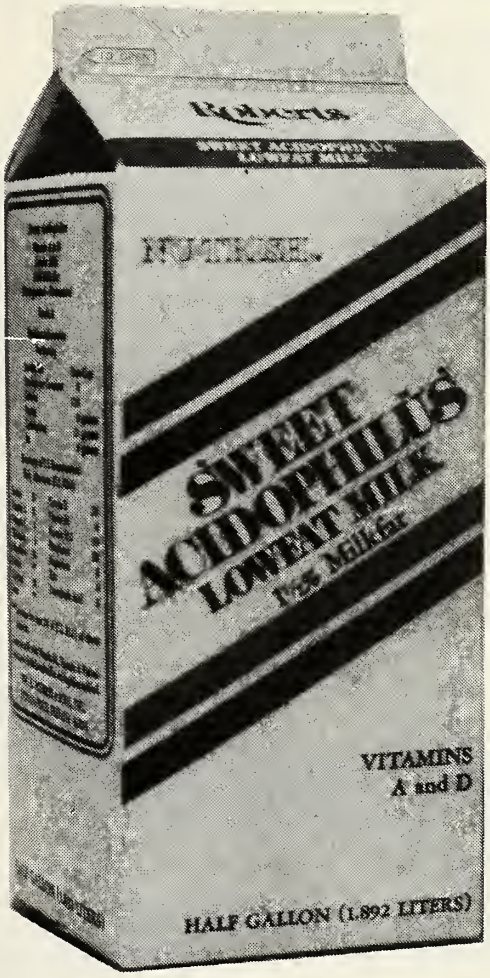
"Since then, Lilly scientists have discovered or developed more than 60 new medicines and agricultural products. Today, happily, we stand at a new launch point for the life sciences. Modern research techniques have made it increasingly possible to study drug action and disease process at the molecular level. This means that medicines and agricultural products will be more specifically designed for their functions and should thus be safer and more effective.

"After 100 years, we still have integrity, compassion, and a thirst for excellence. I am especially grateful for a loyal and gifted brother and for a father who all his life believed that man is a magnificent creature and, in the process, became one himself. They are with me in spirit as we celebrate our 100th anniversary." ◄



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The raw acidophilus culture used in Robert's Sweet Acidophilus milk is an especially chosen strain. It can survive the acid conditions of the stomach and bile salts and does not affect the sweet, delicious taste of low-fat homogenized milk.

The special culture strain is harvested and concentrated using special procedures developed by scientists at North Carolina State University. It is the result of the painstaking research of these scientists that provides the consumer with the benefits of Robert's Sweet Acidophilus low-fat milk.

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When Robert's Sweet Acidophilus milk is consumed, the tiny acidophilus cells find their way to the intestines. In the intestines, there are millions of bacteria working beneficially helping to digest the food.

The acidophilus cells work in a manner that acts to discourage certain intestinal disorders such as diarrhea, flatulence (gas) and other discomforts that are caused by failure to digest food properly.

Those people receiving antibiotic drugs will especially welcome Robert's Sweet Acidophilus milk, for it will reestablish the microbiological population of the intestines, helping to overcome some of the discomforts some people experience after receiving antibiotics.

Most dairy men and scientists believe that Robert's Sweet Acidophilus milk is the modern milk and that some day in the future, most of the low-fat milk sold will contain the acidophilus cells that provide something extra when added to refreshing, delicious milk.

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FUTURE MEETINGS, SEMINARS, COURSES

Courses Announced by I.U.S.M.

The following programs have been scheduled by the Indiana University School of Medicine's Division of Postgraduate and Continuing Medical Education:

Oct. 20 CARDIOPULMONARY WORKSHOP FOR PRACTICING PHYSICIANS
St. Joseph Memorial Hospital, Kokomo

Oct. 21 THROMBOEMBOLIC DISEASE — CURRENT CONCEPTS
Reid Memorial Hospital, Richmond

Nov. 3 OTOLARYNGOLOGY WORKSHOP FOR THE PRACTICING PHYSICIAN
St. Joseph Memorial Hospital, Kokomo

Nov. 5 RECENT CLINICAL ADVANCES IN THE MANAGEMENT OF THE PATIENT WITH MALIGNANT DISEASE
Stouffer's Inn, Indianapolis
(Co-sponsored by the Indiana Division of the American Cancer Society and Adria Laboratories)

Nov. 19 CLINICAL ELECTROENCEPHALOGRAPHY FOR NEUROLOGISTS
Indiana University Medical Center, Indianapolis (limited to 30 participants)

Dec. 1-2 TREATMENT AND MANAGEMENT OF CHRONIC OBSTRUCTIVE LUNG DISEASE
Holiday Inn Airport, Indianapolis

Information on any of these courses may be obtained by writing Mr. John Roscoe, 317 Fesler Hall, 1100 W. Michigan St., Indianapolis 46202.

Dr. Selenkow, Others to Conduct Ames Company's Thyroid Seminar

The Ames Company is sponsoring a two-day symposium on recent advances in thyroid physiology, diagnosis and therapy, to be held at Elkhart on Oct. 22 and 23. The chairman, Herbert A. Selenkow, M.D., associate professor of medicine at Harvard Medical School and Thyroid Unit, Peter Bent Brigham Hospital, will be supported by a staff of visiting specialists. The registration fee of $75 includes all materials, reception and banquet. Enrollment is limited to 100. Call Dr. James A. Jackson, Ames Company, 1127 Myrtle St, Elkhart, IN 46514; phone 219-264-8453.

Course in Professional Corporations And Money Management Announced

The complexities of the professional corporation and efficient money management will be explored at a two-day course offered by the Indiana University School of Dentistry at the Airport Hilton Inn, Indianapolis, Oct. 23 and 24.

Harvey Sarner, an attorney in private practice in Chicago who also serves as an instructor in Dental Jurisprudence at the I. U. School of Dentistry, will conduct the course, for which the fee is $100 for doctors and $35 for auxiliaries or wives (two luncheons are included).

Further information may be obtained by writing to Dr. Robert H. Derry, Director of Continuing Education, I.U School of Dentistry, 1121 W. Michigan St., Indianapolis 46202.

Symposium on Polytomography Of Temporal Bone Announced

The 15th two-day Symposium on Polytomography of the Temporal Bone will be given under the auspices of The Wright Institute of Otology at Community Hospital, Indianapolis, on Nov. 6 and 7, 1976. This continuing Medical Education activity is acceptable for 12 credit hours in Category 1 for the AMA Physician's Recognition Award (PRA).

Subjects covered are: "Basic Anatomy of the Temporal Bone" and "Technic of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography, such as cholesteatoma, ossicular chain problems, otosclerosis, fractures, foreign bodies, tumors, and congenital anomalies are shown on original tomograms and the clinical applications discussed.

Number of registrants is limited to 20. Fee for the course is $250.

Inquiries should be directed to: The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis, 46219.

Seminar on Pediatric Emergencies

"Pediatric Emergencies—Little People, Big Problems" will be presented Nov. 21 to 24 at the Orlando, Florida, Hyatt House. It is sponsored by the Florida Chapter of the American College of Emergency Physicians. For full information contact Registrar, Pediatric Emergencies, 1919 Beachway Road, Suite 5C, Jacksonville, Fla. 32207; 904-399-0510.

"Primary Care" Workshop at Chicago

"Issues in Primary Care" will be the theme of a workshop to be held at the Continental Plaza Hotel, Chicago, on Friday, Dec. 3. It will be conducted by the Institute of Medicine of Chicago and will devote the entire day to presentations on "Primary Care Personnel," "Education of a Primary Care Physician," "Economic Factors" and "Description of Services." Registration fee is $40 for Fellows of the Institute and $45 for non-members. This includes luncheon and coffee breaks. The address is 919 N. Michigan Ave., Chicago 60611.

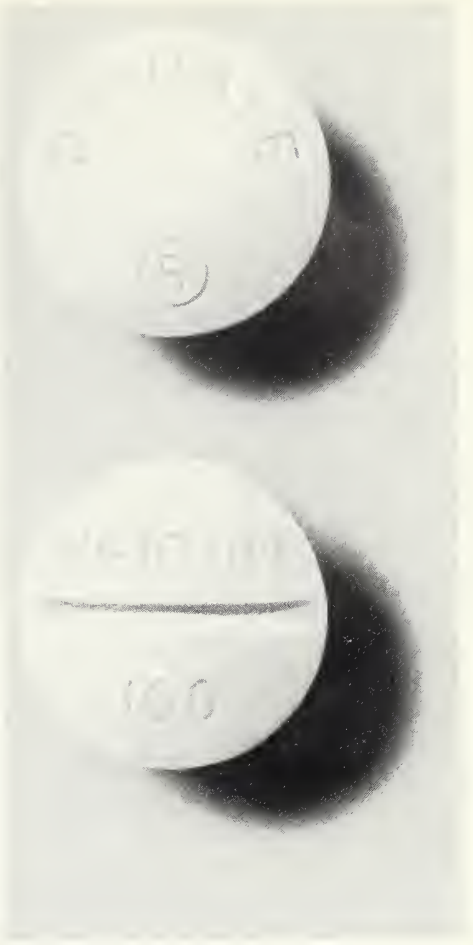
Hematological Disorders Seminar

St. Mary's Hospital Graduate Medical Center, Evansville, announces a seminar on hematological disorders for Thurs., Nov. 11. Topics will include Iron Deficiency Anemias, Drug-Induced Hemolytic Diseases, Hereditary Hemolytic Diseases and Transfusion Therapy. Further information may be obtained from the hospital's Graduate Medical Center, 3700 Washington Ave., Evansville 47750; 812-479-4467.

Blood Components and Use Seminar Topic

Dr. William Sgouris will be the guest speaker for a symposium titled "Blood Components and Their Use" that is planned for Dec. 4 by the Indiana Association of Pathologists and Indiana Society of Medical Technology at the Martin House, Indianapolis. Contact Jan Andre, 2304 Ellen Drive, Lafayette 47905, for information and reservations. ◄

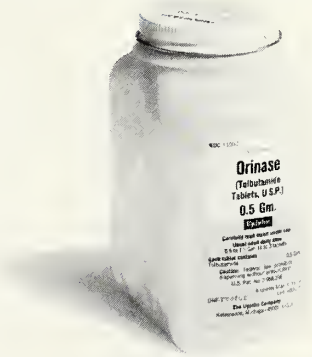
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Schedule for Upcoming NCME Programs

The Network for Continuing Medical Education announces the following schedule of programs:

Oct. 18-31

HYALINE MEMBRANE DISEASE: ASSESSING LUNG MATURITY, with Louis Gluck, M.D., professor of pediatrics and obstetrics, University of California San Diego, LaJolla.

THE CLINICIAN AND THE LABORATORY; INFECTIOUS DISEASES, with Richard H. Parker, M.D., Chief of Infectious Disease, Veterans Administration Hospital, and Associate Professor of Medicine, Howard University, Washington, D.C.

DYSPNEA: SIGNAL OF DISEASE? with Kenneth M. Maser, M.D., Director of the Pulmonary Division, and Professor of Medicine, University of California, San Diego.

Nov. 1-14

HYPERTENSIVE RETINOPATHY: FUNDUSCOPIC FEATURES, with Richard E. Goldberg, M.D., Director, and Larry E. Magargal, M.D., co-director, the Retinal-Vascular Unit, Wills Eye Hospital, Philadelphia.

LACTIC ACIDOSIS: PATHOGENESIS AND ETIOLOGY, and LACTIC ACIDOSIS: DIFFERENTIAL DIAGNOSIS AND TREATMENT, with Philip Felig, professor and vice chairman, Department of Internal Medicine, and chief, Endocrinology Section, Yale University School of Medicine and Yale-New Haven Hospital.

Nov. 15-28

FIBEROPTIC BRONCHOSCOPY: ITS USES AND ADVANTAGES, with Bernard Marsh, M.D., associate professor of otolaryngology, The Johns Hopkins University School of Medicine, and director, Brayles Brancascapic Clinic, Johns Hopkins Hospital, Baltimore.

ALCOHOL INGESTION: ACUTE METABOLIC SYNDROMES, with Philip Felig, M.D., professor and vice-chairman, Department of Internal Medicine, and Chief, Endocrinology Section, Yale University School of Medicine and Yale-New Haven Hospital.

CAT SCANNING: A NEW DIMENSION, with John R. Haaga, M.D., radiologist, The Cleveland Clinic, Cleveland, Ohio.

(Program scheduling subject to change)

For more information about NCME, write The Network for Continuing Medical Education, 15 Columbus Circle, New York, NY 10023.

Elected to College Board of Trustees

Indiana Central University, Indianapolis, has named **Dr. Robert W. Briggs, Indianapolis** internist, to its board of trustees.

Continuing Medical Education

The following Indiana physicians are recent winners of the coveted AMA Physician's Recognition Award:

Malcolm K. Baird, Crawfordsville
Bradley N. Boen, Terre Haute
Thomas A. Brubaker, Muncie
Stanley M. Chernish, Indianapolis
Angel Cordano, Evansville
Julio E. Cosio, Jeffersonville
Martin T. Feeney, Indianapolis
Manuel B. Gabato, Crown Point
Hugh E. Glock, Greencastle
Elton Heaton, Madison
James B. Johnson, Greencastle
Joseph D. McDonald, Evansville
David M. O'Brien, Columbus
Edsel S. Reed, Jeffersonville
Ben V. Roberto, Austin
Matthew C. Shaw, Muncie
James R. Van Curen, Goshen
Donald L. Wilson, Indianapolis
Edward J. Berman, Indianapolis
Arlin E. Brown, Bloomington
Flor T. Castueras, Salem
Eleanor Clay, Columbus
Thomas A. Cortese, Indianapolis
Bennie L. Davis, Indianapolis
Phillip D. Foley, Middletown
Jonathan P. Gentile, Fort Wayne
Robert F. Green, Fort Wayne
Herman L. Hirsch, Mt. Vernon
Jerry L. Mackel, Fort Wayne
Wilbur D. McFadden, North Manchester
Robert M. Palmer, Indianapolis
Paul D. Riley, Indianapolis
Gilbert A. Sartore, Evansville
Robert R. Taube, Connersville
Charles J. Van Tassel, Indianapolis

Dr. Batchelder Cardiology Fellow

Dr. John E. Batchelder, Indianapolis, has been elected a Fellow of the American College of Cardiology, according to an announcement by **Dr. Morton E. Tavel, Indianapolis,** governor of the Indiana Division.

Reorganized YMCA Chooses Dr. Johnloz

Dr. David Johnloz, Bloomington internist, has been named to the board of directors of the newly organized Monroe County Family YMCA.

Child Safety Catalog Offered

"Catalog Child Safety" is published by the Safety Now Company to list over 200 products selected especially for promotion of safety of children from infancy to teen age. The list includes the new book by Murl Harmon "A New Vaccine for Child Safety," but the catalog itself is said to promote proper concern for child safety when parents read it. A free copy of the catalog is obtainable by writing Safety Now Co. Inc., Box 567, 202 York Road, Jenkintown, Pa. 19046.

Dr. McAtee Defends State Hospitals

Dr. Ott B. McAtee, superintendent of the Madison State Hospital, is a co-author of an article titled "In Defense of the State Hospital," which appears in the September issue of *Hospital and Community Psychiatry,* the journal of the American Psychiatric Association.

Owen County's Dr. Kay Retires

Dr. Oran E. Kay, Spencer, who has held the post of Owen County Health Officer for the past 28 years, retired in August. He retired from active medical practice in 1965.

Dr. Robert Rose will serve as Health Officer.

Dr. Klepinger Named by Hospital

Dr. Harry E. Klepinger, Lafayette, has been named medical director of the Home Hospital's skilled nursing facility. He is a former president of the medical staffs of both Home and St. Elizabeth hospitals.

Grand Rounds in Surgery Announced

"Grand Rounds in Surgery" will appear live from Indiana University School of Medicine with telephone talkback on the WAT 21 Medical Television program on the first Wednesday of each month at 12 noon, Indianapolis time. Each of the 31 hospital or clinic WAT 21 outlets will carry the series. The program for the remainder of 1976-77 is as follows:

1976

Nov. 3 RENAL TRANSPLANT IN INDIANA, Ronald Filo, M.D.

Dec.1 THERAPEUTIC APPROACH TO NECK MASS, William Cocke, M.D.

1977

Jan. 5 ORTHOPAEDIC PROBLEMS IN CHILDHOOD, Richard Lindseth, M.D.; Paul DeRosa, M.D.

Feb. 2 CARCINOMA OF THE BREAST: A COMBINED APPROACH, James A. Madura, M.D.

Mar. 2 CURRENT STATUS OF CORONARY ARTERY RECONSTRUCTIONS, Robert King, M.D.

Apr. 6 ANESTHETIC CONSIDERATIONS OF IMPORTANCE TO THE SURGEON, Robert Stoelting, M.D.

May 4 CARCINOMA OF THE COLON, John E. Jesseph, M.D.

Resident-Intern Insurance Available

New malpractice insurance is now available to members of the National Association of Residents and Interns. An occurrence-type policy will be available for interns, residents, fellows and physicians in the military services in most states. The Glacier General Assurance Company of Missoula, Mont., is the carrier.

Bicentennial Open House Held

The Associated Physicians and Surgeons Clinic at Terre Haute held an Open House recently commemorating the Bicentennial. Medical instruments and other artifacts from the State Medical Museum were on display and attracted much interest. Visitors were invited to join with the physicians "in remembering the past, celebrating the present and expressing faith in the future of medical care in the Wabash Valley.

Family Physician Academy Elects

New officers of the Indiana Academy of Family Physicians are:

Dr. Malcolm Scamahorn, Pittsboro, president-elect; Dr. Paul A. Williams, Rensselaer, vice-president; Dr. Wilson L. Dalton, Shelbyville, national delegate; Dr. Alvin J. Haley, Fort Wayne, alternate delegate; Dr. James M. Kirtley, Crawfordsville, speaker of the house; Dr. Ronald Blankenbaker, vice-speaker of the house, and Dr. Robert P. Acher, Greensburg, budget committee member at large.

Dr. Kenneth E. Bobb, Seymour, is president.

New Film: "When Your Clothing Burns"

The National Fire Protection Association has a public education film entitled "When Your Clothing Burns." It is in color, 16 mm, and runs about 18 minutes. A complete analysis of flammable fabrics and flame retardants comprises a major portion of the film, coupled with explanations of personal burn-prevention habits, such as how to extinguish flames should your clothes catch on fire. The film is for sale at an introductory price of $210. After November 30 the price will be $235. The address is 470 Atlantic Ave., Boston 02210.

THE ARMED FORCES ENTRANCE AND EXAMINING STATION, 141 S. MERIDIAN ST., INDIANAPOLIS, INDIANA, HAS AN IMMEDIATE OPENING FOR A PHYSICIAN TO CONDUCT PHYSICAL EXAMINATIONS. FULL LICENSURE REQUIRED. AGE NO BARRIER. FINANCIAL ASSISTANCE AVAILABLE FOR RELOCATION. STARTING SALARY, $25,200 PER YEAR WITH PERIODIC AND COST OF LIVING INCREASES. FULL FEDERAL EMPLOYEE BENEFITS SUCH AS VACATION LEAVE, SICK LEAVE, LIFE AND HEALTH INSURANCE AND A RETIREMENT PROGRAM. AN EQUAL OPPORTUNITY EMPLOYER. CALL COLLECT OR WRITE TO U.S. ARMY RECRUITING COMMAND, CIVILIAN PERSONNEL DIVISION, BLDG. 50A, FORT SHERIDAN, ILLINOIS 60037. PHONE 312-926-3911/3406.

NEWS NOTES

Hoosier Physicians Announce Retirement

Among Hoosier physicians who have recently announced their retirement are the following:

Dr. Glenn Conway, Indianapolis, has closed his office after serving 51 years in the medical profession.

Dr. Julia Adams, Muncie, physician in the Ball State University Health Center on a part-time basis since 1956, has retired from the university faculty.

Dr. C. Emil Kenyon, Cambridge City, retired after 42 years of medical practice. He is a former president of the Wayne County Medical Society.

Dr. Robert J. Miller, Paragon, closed his office last June. He had practiced in Paragon since 1961.

Dr. Anton Paul Hattendorf, Fort Wayne proctologist, retired October 1. His 45-year career includes service as Allen County coroner and health commissioner.

Dr. Frederick C. Schwartz, who practiced obsetrics at Kokomo for more than 30 years, retired June 1, and announcement was made at the community dinner honoring him that the St. Joseph Memorial Hospital Foundation has established the Dr. Frederick C. Schwartz Children's Fund. A past president of the Howard County Medical Society, Dr. Schwartz is a past chief of staff of both Howard Community Hospital and St. Joseph's.

Named Dermatology Department Chairman

Dr. Arthur L. Norins, member of the dermatology faculty at I.U. School of Medicine since 1964, and acting chairman of the department since last January, has been named chairman. He succeeds **Dr. Victor Hackney,** who resigned to return to Oklahoma.

Dr. Hendershot "Distinguished" Alumnus

Dr. Eugene Hendershot, Evansville, was among the distinguished alumni honored at a recent banquet by the University of Evansville.

Dr. Owen Johnson Memorial Fund Set Up

Miami County physicians, headed by project chairman **Lloyd L. Hill,** hope to raise $2,000 to redecorate the circus arena bandloft in honor of the late Dr. Owen Johnson, former circus doctor, board member and clown. Those wishing to contribute may make their checks payable to the "Owen B. Johnson Memorial Fund" and mail to Dr. Hill at 802 N Duke St., Peru 46970.

Masonic Order Honors Dr. Row

The 50-year Award of Gold in Masonry was presented recently to **Dr. George S. Row, Osgood.** Dr. Row, who is semi-retired, has been in the practice of medicine for 43 years.

Welborn Hospital Staff Officers Chosen

Newly elected to the medical staff at Welborn Baptist Hospital, Evansville, are **Dr. Jack Williams,** president; **Dr. Marshall Miller,** secretary-treasurer, and **Dr. Alfred Lessure,** president-elect. Other members of the committee are **Dr. John Lawler,** immediate past president, and three members-at-large: **Drs. Isaac Hargett, Kerry Newman** and **James Marvel.** Chosen chairman of various departments were: **Dr. Theodore Pavlick,** surgery; **Dr. Larry Beisel,** pediatrics; **Dr. Leon Stoller,** obstetrics and gynecology, and **Dr. William Vincent,** medicine.

Dr. Glock Certified by Anesthesia Board

Dr. Douglas E. Glock, Marion, has been inducted as a Fellow of the American Academy of Orthopaedic Surgeons.

Physician Legislator on Study Committee

Dr. Anthony Pizzo, Bloomington Hospital pathologist and State Representative, has been named vice-chairman of the Physicians' Assistants and Ancillary Personnel Interim Study Committee by House Speaker Phillip Bainbridge.

Dr. Irwin Cited as "Modern Pioneer"

Dr. Glenn W. Irwin, Jr., vice-president of Indiana University for Indiana-Purdue University, Indianapolis, received the first Modern Pioneer Award from the Latter-Day Saints Business and Professional Association. He was chosen for helping develop the Statewide Medical Education Program while he was dean of the I.U. Medical School.

Address Mental Health Workers

Dr. Hugh Hendrie, chairman of the psychiatry department at the Indiana University of Medicine, and **Governor Otis Bowen,** were among the speakers at the recent leadership conference of the Indiana Mental Health Association.

Dr. Hendrie also addressed the first annual membership meeting of the Comprehensive Mental Health Services of East Central Indiana in Muncie in July.

Presents Paper in England

Dr. Dick L. Bennett, Bedford, presented a paper on "General Medical Practice in the United States" at a seminar held recently at the Postgraduate Medical Education Center, Windsor, England.

Dr. Price Advances at Lilly's

Dr. Francis W. Price, Indianapolis, has been promoted to assistant director of the industrial medicine division of Eli Lilly and Company. He joined the company as a staff physician in 1967 and was named manager of industrial medicine in 1968. Before joining Lilly's, Dr. Price was in private practice in Indianapolis.

Dr. Gitlin Named to AMA Committee

Dr. William A. Gitlin, Bluffton, has been named to the American Medical Association's Medicine and Education Committee on School Health. He represents the National School Boards Association, for which he is a member of the board of directors and executive committee. Dr. Gitlin is a longtime member of the Bluffton-Harrison School Board.

Rehabilitation Director Named

Dr. Philip D. Hedrick, Indianapolis, has been named medical director of Crossroads Rehabilitation Center.

Named Foundation Director

Dr. Luis N. Galup, South Bend pathologist, has been appointed director of the South Bend Medical Foundation. He succeeds **Dr. Jene R. Bennett,** who has been with the foundation since 1947 and is stepping down to devote full time to clinical work. ◄

Deaths

Sam W. Campbell, M.D.

Dr. Sam W. Campbell, 56, New Castle, died June 12 in Ontario, Canada, while on a fishing trip. He was staff radiologist at Henry County Memorial Hospital where he had worked for the past 10 years.

A 1943 graduate of the Indiana University School of Medicine, Dr. Campbell was an intern and resident in orthopedic surgery at Indianapolis City Hospital. He was in general practice in Noblesville from December 1947 until July 1966, when he moved to New Castle. He was a radiology resident at the Indiana University Medical Center in 1965 and 1966.

During World War II Dr. Campbell was in the orthopedic surgery service at Wakeman General and Fitzsimons General Hospital, retiring from the Army Medical Corps in August 1947.

He was a member of the American Medical Association, Henry County Medical Society and the Indiana Roentgen Society.

Robert H. K. Foster, M.D.

Dr. Robert Henry King Foster, 74-year old Franklin physician and anesthetist, died July 18 at Johnson County Memorial Hospital.

Dr. Foster graduated from the Rush Medical College, University of Chicago, in 1935, where he had obtained a Ph.D. degree in 1932. From 1936 to 1945 Dr. Foster was chief pharmacologist at the Hoffman-LaRoche laboratories at Nutley, N.J., later serving as professor and director of the Department of Pharmacology at St. Louis University. He came to Indiana in 1952 and served as chief of staff at Johnson County Memorial Hospital and medical director at the Franklin United Methodist Home.

In 1958 he served as president of the Johnson County Medical Society and was a delegate to the ISMA annual meeting on two occasions; he also served on the Commission on Special Activities and attained senior membership in 1973. He was a member of the American Medical Association.

Paul H. Martin, M.D.

Dr. Paul Herbert Martin, Elkhart, died in Elkhart General Hospital June 20. He was 76.

He served 17 years with the Elkhart County Health Unit as commissioner of health and was Elkhart County's first full-time health commissioner. He retired in 1973.

Dr. Martin received his M. D. degree from the Indiana University School of Medicine in 1924 and was in private practice at Ligonier from 1926 to 1931. He then entered the Army Medical Corps and retired in 1953 with the rank of colonel, having held several teaching positions.

A Fellow of the American Public Health Association, Dr. Martin served as vice-chairman and later as chairman of the Section on Public Health and Preventive Medicine.

In 1974 he was inducted into the ISMA 50-Year Club; he was a member of the Elkhart County Medical Society and the American Medical Association.

Bernard J. Matthews, M.D.

Dr. Bernard Joseph Matthews, 76, died May 17 at his home in Indianapolis. Following his retirement in 1970, Dr. Matthews served as a part-time anesthetist at St. Francis Hospital.

He graduated from St. Louis University Medical School in 1928 and served an internship and residency at St. Vincent Hospital. He maintained an office on East 10th Street for 40 years and was on the medical staff at St. Francis and Community hospitals.

A member of the American Medical Association and the Marion County Medical Society, Dr. Matthews became a senior member of the Indiana State Medical Association in 1970.

Eleanor H. McIlwain, M.D.

Dr. Eleanor Harper McIlwain, 76, died March 31 at Memorial Hospital in South Bend. She and her husband, Dr. Robert McIlwain practiced together for 35 years until their retirement in 1967, when they moved to Culver. For 10 years they were physicians at the Methodist Memorial Home in Warren and at the Emily Flinn Home in Marion. She was an ophthalmologist.

A 1925 graduate of the Indiana University School of Medicine, Dr. McIlwain interned at Children's Hospital, San Francisco.

She was a senior member of the American Medical Association and a former member of the Grant County Medical Society.

Richard G. Mehne, M.D.

Dr. Richard Gerald Mehne, 50, Brazil, died July 21 in Clay County Hospital.

Following his graduation from Northwestern University School of Medicine in 1951, Dr. Mehne interned at Cook County Hospital, Chicago, then practiced for a short time at Wheeling, W. Va. He had practiced at Brazil since March 1953.

He was a veteran of World War II, spending 26 months in the infantry and served in the European Theater.

Dr. Mehne served as president of the Clay County Medical Society and was a member of the American Medical Association.

Lyman Overshiner, M.D.

Dr. Lyman Overshiner, Columbus, 89, died at the Four Seasons Home June 16. He retired in 1970 after 50 years of service to the Columbus community in surgery and radiology. He was medical director for the Cummins Engine Company for many years.

He received his M.D. degree in 1917 and then spent 18 months in France, Germany and Italy in World War II.

A senior member of the Indiana State Medical Association, Dr. Overshiner was also a member of the 50-Year Club, and of the American Medical Association.

William C. Schulze, M.D.

Dr. William Carl Schulze, retired Vincennes physician, died July 8 at his home in Clinton. He was 72.

He obtained his medical education at the Eclectic Medical College, Cincinnati, graduating in 1928.

Dr. Schulze was a former member of the medical staff of Good Samaritan Hospital.

He was a former member of the Knox County Medical Society and the American Medical Association.

John V. Thompson, M.D.

Dr. John Vernon Thompson, 62, former Indianapolis thoracic and cardiovascular surgeon, died at Pompano Beach, Fla, where he had made his home since his retirement in 1970.

He interned at Ancker Hospital following his graduation from the University of Illinois School of Medicine in 1939 and was a resident at the University of Illinois Research and Education Hospital from 1942 to 1945.

Dr. Thompson was on the medical staff of the Methodist and St. Vincent hospitals and on the consulting staff of St. Francis and Community hospitals and the Indiana State Sanatorium, Rockville. He was a member of the Marion County Medical Society and the American Medical Association.

Fred L. Toumey, M.D.

Dr. Fred L. Toumey, Indianapolis otolaryngologist, died May 14 at his home. He was 62.

A 1940 graduate of the Indiana University School of Medicine, Dr. Toumey interned at Indianapolis General Hospital and was a resident at the Indiana University Medical Center from 1946 to 1948.

During World War II Dr. Toumey served in England with the Army Air Force Medical Corps.

He was a member of the American Medical Association and the Marion County Medical Society, serving as a delegate to the annual meeting of the Indiana State Medical Association from 1972 to 1975.

Malcolm L. Wrege, M.D.

Dr. Malcolm Lee Wrege, 52, board member and former chief of staff of Community Hospital, Indianapolis, died June 7 in the hospital.

Dr. Wrege did graduate work at the University of Michigan and Harvard University following his graduation from the Indiana University School of Medicine. His residency training in general surgery was at Hurley Hospital, Flint, Mich.

Active in the affairs of the Marion County Medical Society and the Indiana State Medical Association, Dr. Wrege served on the Commission on Constitution and Bylaws from 1970 to 1973, was county society secretary in 1970 and a delegate to the annual meeting from 1967 through 1975. He was also a member of the American Medical Association.

What's New in Books?

Lippincott has published A CORONARY EVENT, written by Michael Halberstam, M.D., and Stephan Lesher. Lesher is a Newsweek reporter who plays the the main character in the book, a patient with coronary thrombosis. Dr. Halberstam, a noted medical writer, was the clinician in the case. One reviewer said: "A CORONARY EVENT should probably be read by everyone who has a doctor. Or a patient. Or a heart—I was engrossed." It is an alternate selection of the Literary Guild and a main selection of the Modern Psychology Book Club. 208 pages, $8.95.

* * *

Crown Publishers has released "The Truth About Fiber In Your Food." The author is Lawrence Galton, a medical writer and former visiting professor at Purdue. Galton spent months with medical researchers and scientists who are working on dietary fiber. Dr. Denis P. Burkett, one of the experts, recommends the book. Price $8.95.

* * *

Doubleday recently released a book "Child Alive," which is a psychological study of infants. It is a collection of essays dealing with aspects of development such as play, language and mother influence. Edited by Roger Lewin, science editor of "New Scientist" in London. 227 pages, price $2.95.

* * *

D. C. Heath and Company announces a new book published by Lexington Books. "Identifying Hyperactive Children," authored by sociologist Peter Conrad of Drake University, dwells on the observation that hyperactivity is manifest in different children according to their environment. A child may be hyperactive in school and not at home and vice versa. This tends to obscure the diagnosis and suggests the advisability of examining the social systems or environments in addition to examining the child. 128 pages; $13.00.

* * *

The National Cancer Institute has produced an 80-page booklet, "The Leukemic Child," in an effort to provide guidance and assistance to parents of children with leukemia. Parents may write to National Cancer Institute, Office of Cancer Communications, Bethesda, Md. 20014, for copies.

* * *

The Charles Press Publishers announces "The Charles Press Handbook of Current Medical Abbreviations." It presents over 5,000 entries. More than 30 medical specialties contributed to the basic list. Only those abbreviations found on patients' charts are included. Obsolete and no longer popular abbreviations are not included. 176 pages, $4.95.

* * *

The Safety Now Company has a new book entitled "A New Vaccine for Child Safety," by Murl Harmon. It consists of 250 pages of safety for infants through teenage. It is a move against the Number One killer of children—accidents. Later, the company will issue a catalog of over 200 products for child safety.

* * *

Pantheon releases a new book "Medical Nemesis—The Expropriation of Health" by Ivan Illich. The author thinks everyone would be healthier if there were fewer doctors. This is a rewrite of the British version which has been popular in Europe. Released on May 3, price $8.95.

* * *

Lippincott has just released "Stuttering Solved," written for teachers, speech therapists and parents, by Martin F. Schwartz, Ph.D. Dr. Schwartz' type of therapy has a success rate of 89%, more than three times the rate of any other method. Price—$7.95.

* * *

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From the *Transactions of the Indiana State Medical Society* 100 Years Ago

Placenta praevia is an accident which, though known to the profession since the days of Portal, has not yet had any uniform treatment firmly established in the professional mind, although this treatment has been the subject of numerous monographs, and of many, some of them, indeed, angry discussions.

The rate of mortality in placenta praevia is by no means settled. When Dr. Greenhalgh read the paper to which reference has already been made, and used Read's statistics, giving a mortality of one in four and a half of mothers, and a large majority of the children dead, it was objected by Drs. Barnes and Hicks that these statistics were unreliable. In like manner the tables of Sir James Simpson, showing the death of nearly one-third of the mothers and more than one-half the children, did not escape the criticisms of Radford, Robert Lee and Tyler Smith.

But let us see how the matter stands to-day in the most recent investigations. Depaul, **op. cit.**, gives a mortality of one in three of the mothers, and in 328 cases of infants, tabulated by Holst, 220 were dead born. So that it is highly probable the ratios given by Read and Simpson do not vary materially from the expression of the truth. . . . **"Treatment of Placenta Praevia," Theophilus Parvin, M.D., Indianapolis, 1876.**

COMMERCIAL ANNOUNCEMENTS

PHYSICIAN OPENING IN INDIANA REHABILITATION SERVICES INDIANA REHABILITATION SERVICES has openings for physicians in its various divisions. Interested persons should contact Dr. Walter E. Deacon, #1016 Illinois Building, 17 West Market Street, Indianapolis, Indiana, Telephone: 317-633-5961.

EMERGENCY MEDICINE: Minimum guaranty/fee-4-service compensation. Individual to join established three-man group, seeing some 25,000 patients per year. Outstanding nursing staff and hospital near Indianapolis. Flexible scheduling and variety of excellent fringe benefits. Contact Dr. Cooper or Spurgeon toll free: 1-800-325-3982, or send inquiry to Craig Boone, M.D., Emergency Department Director, St. John's Hospital, Anderson, Ind. 46014.

MEDICAL DIRECTOR, excellent opportunity and environment. Physician needed to practice General Medicine in an Outpatient Clinic and 25-bed fully accredited hospital. The location is in the heart of Summer and Winter Sports attractions. The Adirondack Mountains and Lake Champlain form excellent vacationing for our area. Contact: Timothy F. Reardon, Administrator, Elizabethtown Community Hospital, Elizabethtown, New York 12932.

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Open-ended opportunity for a General/Family Practitioner, with or without surgical involvement. Full-time physician is needed, though part-time or "Locum tenens" may be considered.

The community is rural, with a population of approximately 3,000 and a service area of 8-10,000, located 120 miles southwest of Minneapolis, Minnesota. It has a diversified economic base, underpinned by some of the country's most productive agricultural land. It has a broad range of religious, service and social organizations.

The community currently has three general practitioners (one of whom is semi-retired) averaging 60 years of ago. It has two clinics, a 34-bed hospital, a 60-bed nursing home and two pharmacies.

A surgeon and pathologists from Mankato and a radiologist from Albert Lea make regular trips to the community and hospital. Medical specialists are available at Mankato (35 miles) and Albert Lea (25 miles).

For additional information, contact D. H. Gilbert, Wells Municipal Hospital, 400-4th Avenue, S.W., Wells, Minnesota 56097. (507) 553-5904 or 553-3111.

FOR SALE: Five 10 milligram needles and two 5 milligram needles of radium with applicators for use on skin, postnasal space, cervix, uterine cavity. Priced to sell. Box 408, THE JOURNAL, 3935 N. Meridian St., Indianapolis 46208.

FOR RENT: Fully equipped, five-room, physician's office in a town with a recently built accredited hospital facility.—Contact: Dr. R. A. Nason, 123 E. King St., Garrett, Indiana 46738; 219-357-3060.

TAX DEDUCTIBLE VACATIONS for medical professionals. Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10 check or money order payable to Professional Calendars, P.O. Box 40083, Washington, D.C. 20016.

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Yep, sonny, this is sure enough Injun summer. Don't know what that is, I reckon, do you?

Well, that's when all the homesick Injuns come back to play. You know, a long time ago, long af yer granddaddy was born even, there used to be heaps of Injuns around here—thousands—millions, I reck far as that's concerned. Reg'lar sure 'nough Injuns—none o' yer cigar store Injuns, not much. They wuz around here—right here where you're standin'. Don't be skeered—hain't none around here now, leastways live ones. They been gone this many a year. They all went away and died, so they ain't no more left.



But every year, 'long about now, they all come back, leastways their sperrits do. They're here now. You can see 'em off across the fields. Look real hard. See that kind o' hazy, misty look out yonder? Well, them's Injuns—Injun sperrits marchin' along an' dancin' in the sunlight. That's what makes that kind o' haze that's everywhere—it's just the sperrits of the Injuns all come back. They're all around us now. See off yonder; see them teepees? They kind o' look like corn shocks from here, but them's Injun tents, sure as you're a foot high. See 'em now? Sure, I knowed you could. Smell that smoky sort o' smell in the air? That's the campfires a-burnin' and their pipes a-goin'. Lots o' people say it's just leaves burning', but it ain't. It's the campfires, an' th' Injuns are hoppin' round 'em t' beat the old Harry.



You jest come out here tonight when the moon is hangin' over the hill off yonder an' the harvest fields is all swimmin' in the moonlight, an' you can see the Injuns and the teepees just as plain as kin be. You can, eh? I knowed you would after a little while.

Jever notice how the leaves turn red 'bout this time o' year? That's jest another sign o' redskins. That's when an old Injun sperrit gets tired dancin' an' goes up an' squats on a leaf t' rest. Why, I kin hear 'em rustlin' an' whisperin' an' creepin' 'round among the leaves all the time; an' ever' once'n a while a leaf gives way under some fat old Injun ghost and comes floatin down to the ground. See—here's one now. See how red it is? That's the war paint rubbed off'n an Injun ghost, sure's you're born.

Purty soon all the Injuns'll go marchin' away agin, back to the happy huntin' ground, but next year you'll see 'em troopin' back—th' sky jest hazy with 'em and their campfires smolderin' away jest like they are now.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders, athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy).

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful

respond to one

According to her major symptoms, she is a psychoneurotic patient with severe anxiety. But according to the description she gives of her feelings, part of the problem may sound like depression. This is because her problem, although primarily one of excessive anxiety, is often accompanied by depressive symptomatology. Valium (diazepam) can provide relief for both—as the excessive anxiety is relieved, the depressive symptoms associated with it are also often relieved.

There are other advantages in using Valium for the management of psychoneurotic anxiety with secondary depressive symptoms: the psychotherapeutic effect of Valium is pronounced and rapid. This means that improvement is usually apparent in the patient within a few days rather than in a week or two, although it may take longer in some patients. In addition, Valium (diazepam) is generally well tolerated; as with most CNS-acting agents, caution patients against hazardous occupations requiring complete mental alertness.

Also, because the psychoneurotic patient's symptoms are often intensified at bedtime, Valium can offer an additional benefit. An *h.s.* dose added to the *b.i.d.* or *t.i.d.* treatment regimen can relieve the excessive anxiety and associated depressive symptoms and thus encourage a more restful night's sleep.



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in psychoneurotic
anxiety states
with associated
depressive symptoms

surveillance because of their predisposition to habituation and dependence. In pregnancy, lactation or women of childbearing age, weigh potential benefit against possible hazard.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

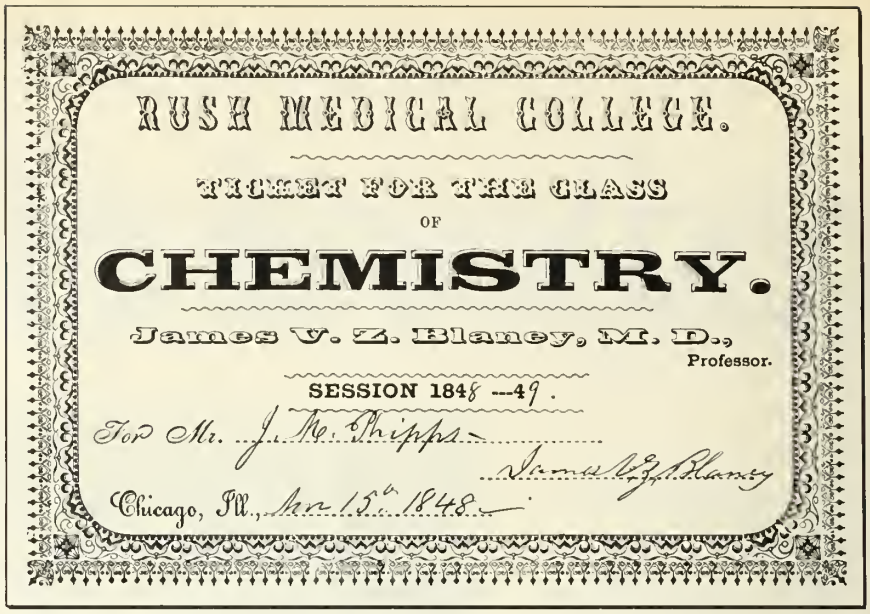
Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MEDICAL MUSEUM NOTES





The Museum has recently acquired five matriculation cards for Rush Medical College, circa 1847-1850. These cards are of interest, not only because Rush has provided the medical education for many Indiana physicians over the years, but also for the particular professors who issued these cards or "tickets." One card indicates that Dr. Daniel Brainard gave the lectures on surgery. Dr. Brainard was the founder of Rush Medical College, which first opened its doors in 1843. The school building, erected in 1844, stood at the corner of Dearborn and Indiana streets in Chicago. It was destroyed in the great fire of 1871.

The card of primary interest for the Museum is that for Obstetrics and Diseases Peculiar to Women and Children. This course was taught by John Evans, M.D., a physician from Attica, Ind., who purchased for the state the land where the Museum now stands, and who built the State's first mental hospital. The date on the ticket, November 1848, is approximately the time that Evans moved from Indianapolis to Chicago.

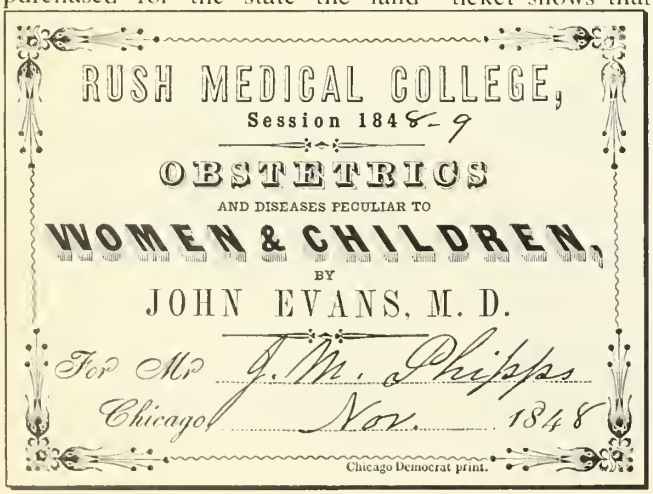
The Chemistry lectures were given by James D.Z. Blaney, M.D., a member of the original faculty. In 1844 this faculty began publication of the *Illinois Medical and Surgical Journal*. Dr. Blaney was its first editor. The following year the name of the publication was changed to the *Illinois and Indiana Medical and Surgical Journal,* with simultaneous publication in Indianapolis and Chicago. Dr. Evans, who was living in Indianapolis at that time, had been appointed to the editorial board.

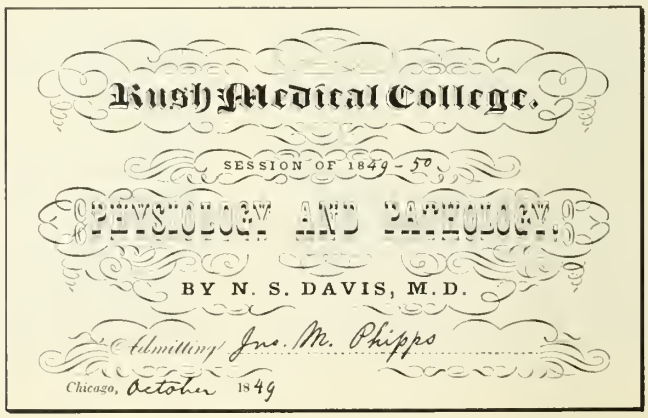
The owner of the Journal was William B. Herrick, M.D., whose ticket shows that he taught Anatomy. When Dr. Evans moved to Chicago in 1848 he became co-owner of the Journal. The name of the publication was changed again to the *Northwestern Medical and Surgical Journal*. By 1851 Evans was the sole owner and editor.

The lectures on Physiology and Pathology were given by Nathan Smith Davis, M.D., the principal organizer of the American Medical Association and first editor of its journal. He was elected to this chair in July 1849.

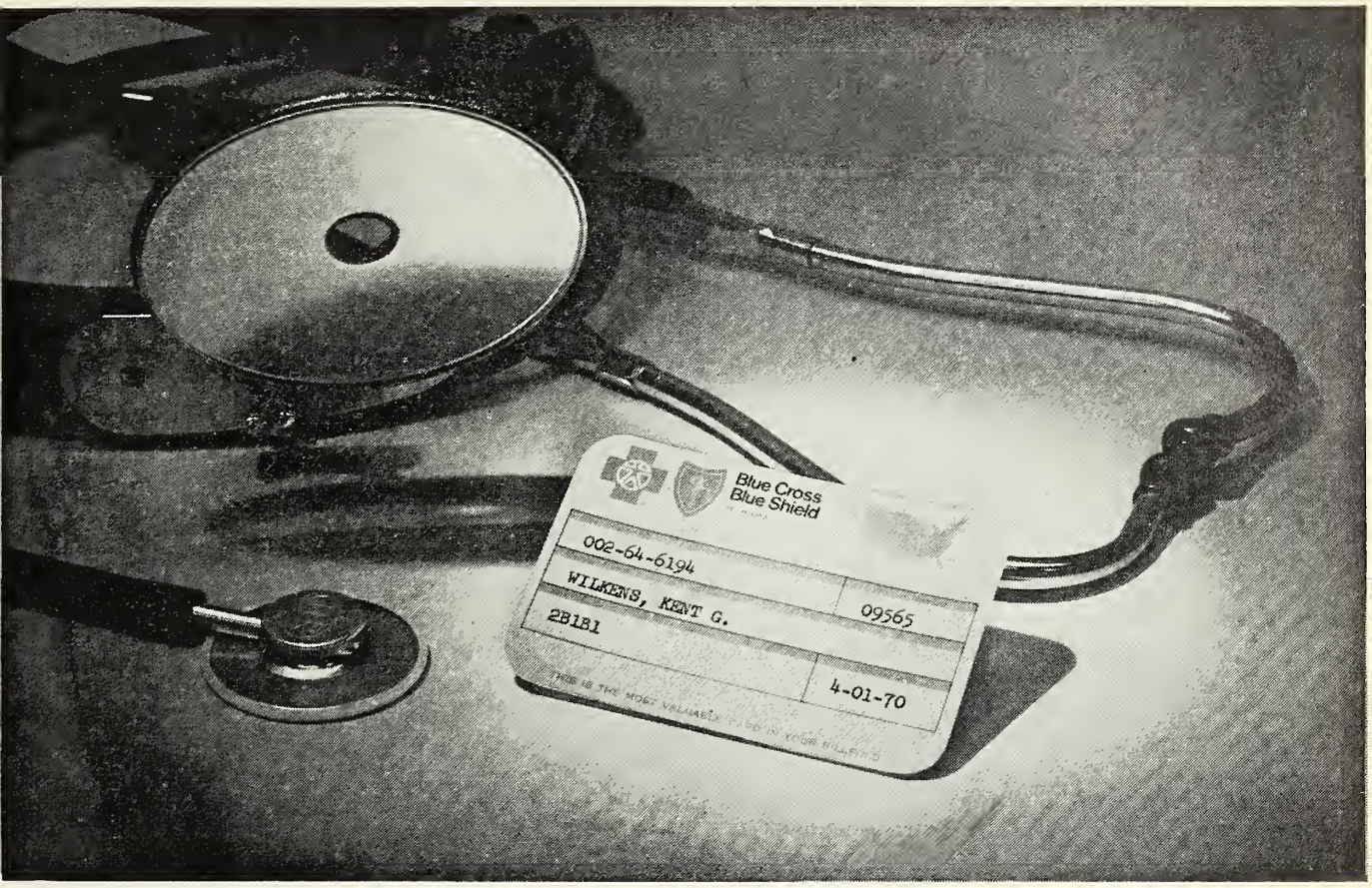
Three of these five cards are reproduced here. They were issued to John M. Phipps, an Indiana physician who would later serve as a regimental surgeon during the Civil War (136th Indiana Volunteers).

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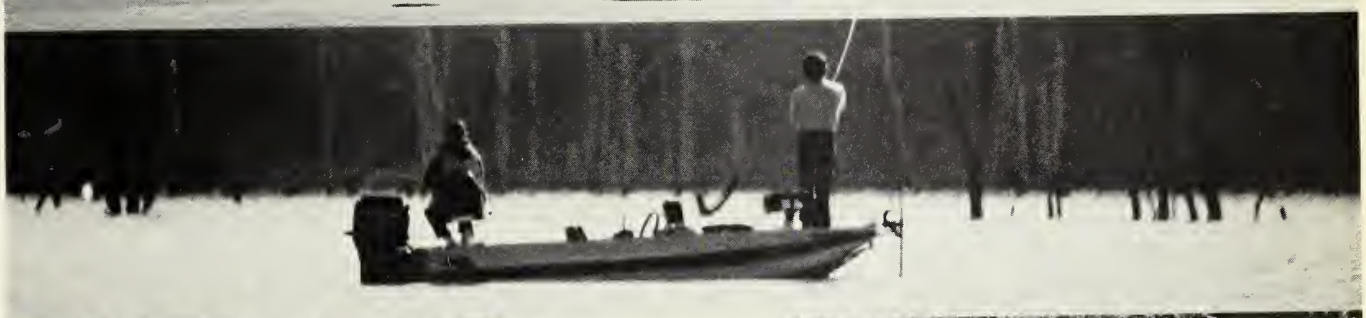
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DELEGATES TO THE AMA

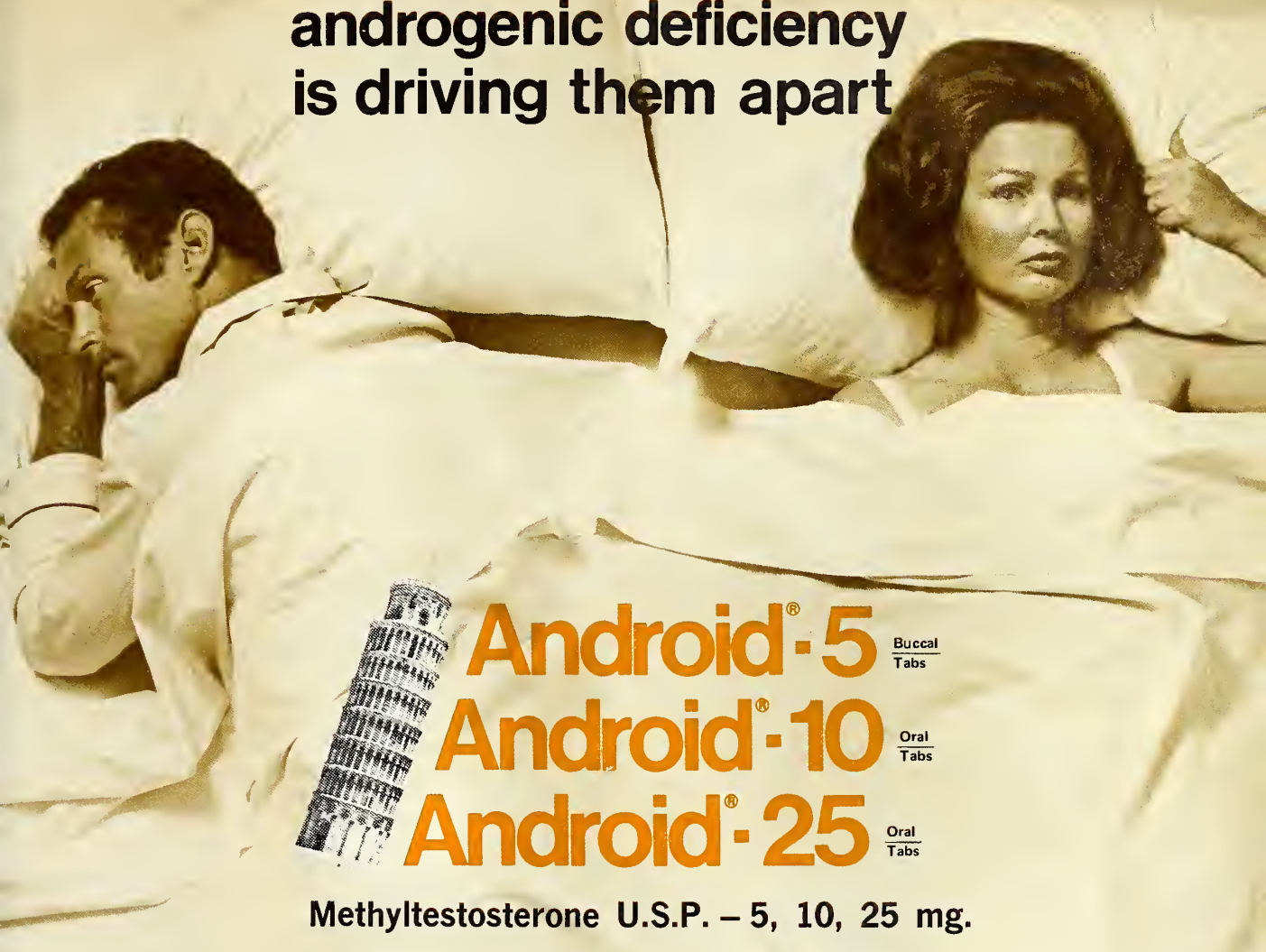
Terms expire December 31, 1977:
Delegates: Patrick J. V. Corcoron, Evansville; Peter R. Petrich, Attica.
Alternates: Thomas C. Tyrrell, Hammond; Marvin E. Priddy, Fort Wayne.

Terms expire December 31, 1978:
Delegates: James A. Harshman, Kokama; Malcolm O. Scamaharn, Pittsbara; Rass L. Egger, Daleville.
Alternates: George Lukemeyer, Indianapolis; Everett Bickers, Floyds Knobs; Gilbert M. Wilhelmus, Evansville.

1976-77 DISTRICT MEDICAL SOCIETY OFFICERS

District	President	Secretary	Place and date of meeting
1.	Herman F. Rusche, Evansville	Forrest F. Radcliff, Evansville	
2.	Robert E. Moses, Warthington	James P. Beck, Washington	
3.	Claude J. Meyer, Jeffersanville	Charles X. McCalla, Paoli	
4.	Ivan T. Lindgren, Aurora	Gerald T. Bawen, Lawrenceburg	
5.	Fred Dettloff, Greencastle	Gregory Larkin, Greencastle	
6.	Clarence C. Clarksan, Richmond	Hal Rhynearson, Fortville	
7.	Jahn M. Recards, Franklin	M. O. Scamahorn, Pittsbora	
8.	Clarence M. Ashburn, Muncie	David J. Dietz, Muncie	
9.	John A. Knote, Lafayette	David L. Evans, Lafayette	
10.	James R. Brawn, Valparaisa	Barron M. F. Palmer, Hammand	
11.	William Dannacher, Wabash	Fred Poehler, La Fantaine	
12.	Thomas A. Felger, Fart Wayne	John Paul Smith, Fart Wayne	
13.	Elmer Billings, Elkhart	Michael G. Quinn, Sauth Bend	

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

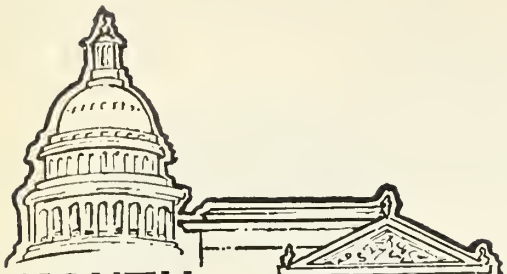
Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

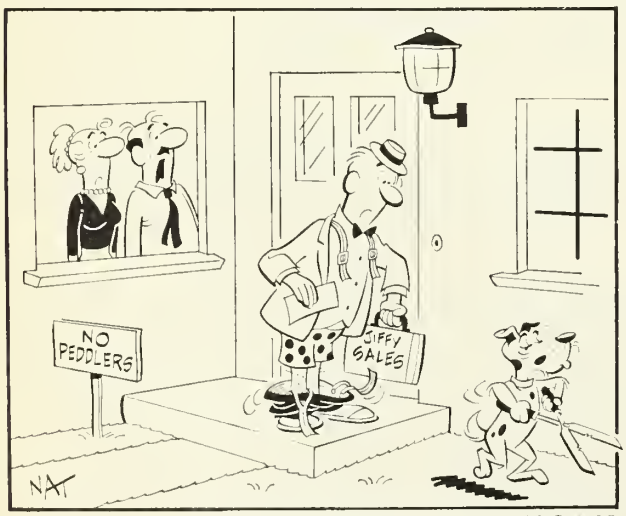
AFTER THREE LONG YEARS of sometimes bitter infighting, Congress has passed legislation to provide more than $2 billion over a three-year period for medical education assistance.

Commenting on the final provisions of the conference committee action, James H. Sammons, M.D., AMA's executive vice-president said, "Many features which we felt were not in the best interests of medical education were dropped—and for this we are very pleased."

Dr. Sammons pointed out that the bill still contains language that will be troublesome but emphasized that "The end results of years of work will be a bill that will—overall—help us increase the supply of physicians and the number of physicians in primary care as well as continued support of the National Health Service corps."

The major battle fought by the AMA, the Administration, and others defeated the prolonged efforts of some to use the so-called Health Manpower bill as a vehicle for federal dictation of curriculum, regional allocations, federal service and licensure of physicians.

As a result of the legislation's passage, medical schools are assured of a continuation of capitation and construction funds, medical students will have increased opportunities for federal scholarships and loan assistance, and the government's National Health Service Corps stands firmly entrenched as an expanding program to channel physicians into shortage areas.



"WHY CAN'T HE JUST NIP AT THEIR PANTS LIKE OTHER DOGS DO?"

In addition, medical schools will be required to produce more "primary care" physicians.

The most controversial feature in the separate bills that had been approved earlier in the House and Senate had been a House provision compelling medical graduates to pay back in money or in shortage area service for the capitation aid their medical schools had received (rather than individual scholarships or loans the students might have taken). This was not contained in the Senate bill or in the final compromise measure worked out by the House and Senate conferees.

Only one burdensome requirement of importance remained in the bill. As a condition for capitation aid, medical schools must have in 1978 at least 35% of their filled first year positions in direct or affiliated residency training programs in primary care, defined as Family Medicine, General Internal Medicine and General Pediatrics. This percentage rises to 50% by 1980.

Rather than requiring certain percentages of medical school graduates to enter shortage area service or join the National Health Service Corps (NHSC), the new medical education bill simply puts up enough PHSC scholarship funds to assure sufficient numbers of young physicians entering the program. Authorized for such scholarships are $75 million for the fiscal year starting this October, $140 million next fiscal year and $200 million for fiscal 1980. Also $51 million over three years was authorized for special scholarships for "students who are of exceptional financial need."

CONGRESS HAS SENT TO THE WHITE HOUSE legislation to expand medical aid for Indians.

The measure, backed by the AMA, authorizes a three-year program for health professions recruitment and preparatory scholarships for Indians, and for scholarship and extern programs to provide physicians, dentists and other health professionals who would provide health services to Indians.

The bill authorizes construction and renovation of Indian Health Service hospitals, health centers, health stations and other facilities. It eases medical standards for Indian Health Service facilities and makes the facilities eligible for Medicare and Medicaid reimbursements.

For the first time, health service activities for Indians in urban areas would be furnished, including outreach programs, identification of Indians and their health needs, assisting Indians to use community health facilities and the direct delivery of services.

HOSPITAL-BASED BLOOD BANKS HAVE CHARGED that the American National Red Cross is threatening "a crisis in blood supply which will have an impact on health care delivery."

At issue is the Red Cross decision after 16 years to cancel its agreement with the American Association of Blood Banks to exchange blood through the AABB's clearinghouse program.

The AABB, which represents most major hospital banks in the country, termed the Red Cross decision—to become effective Oct. 11—a "drastic step" that "will have an adverse effect on the nation's blood supply and will serve to fragment the blood banking system in this country."

The Red Cross was urged by the AABB to reconsider its decision or to agree to national mediation on the issue.

The AABB said it went public with its appeal and protest "not without a great deal of anguish . . . but we no longer have a choice."

THE AMA HAS ASKED CONGRESS to drop a proposed tax provision that would authorize state and local governments to require Social Security numbers to be submitted in administration of any "general public assistance program."

"We are concerned that the term 'general public assistance program' could be defined to include such health programs as local neighborhood health clinics, drug, alcohol or venereal disease programs, as well as the Medicaid programs," said James Sammons, M.D., AMA executive vice-president. ◄

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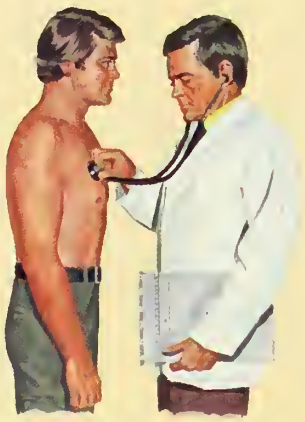
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Narrowing down pneumonias

Upjohn

Bacterial or nonbacterial?

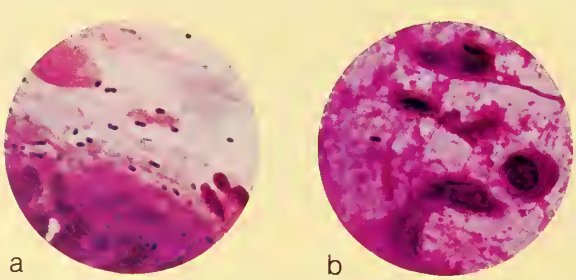
In the early stages of mild to moderate pneumonia, it is often difficult to reach an accurate bacteriologic diagnosis. A tentative differentiation may be made on history-taking, physical examination, CBC with differential analysis, and microscopic study of the sputum smear. Specimens should be obtained for culture and sensitivity testing, but when a bacterial pneumonia is diagnosed, therapy is often instituted before the etiological agent is positively identified.



Bacterial pneumonias may have a sudden onset with a shaking chill, rapid development of fever, pleuritic pain, and cough productive of rust-colored sputum. The Gram-stained sputum smear generally shows polymorphonuclear neutrophils as well as a predominance of the causative organisms. These are likely to be *Streptococcus pneumoniae,* still by far the most frequently encountered agent in bacterial pneumonia.[1] The CBC reveals marked leukocytosis with a shift to the left.

In *nonbacterial pneumonias*—mycoplasmal or viral—classical symptoms tend to develop more slowly, with myalgia, lassitude, and headache predominating. Sputum production is usually scanty, and the sputum smear is relatively uninformative, showing gram-positive cocci and other organisms which are part of the normal pharyngeal flora. The leukocyte count is normal or slightly elevated.

Direct Gram-stained sputum smears. (a) Pneumococcal pneumonia—note abundant polymorphonuclear leukocytes, as well as gram-positive diplococci. (b) Nonspecific—consistent with viral or mycoplasmal pneumonia. Note large mononuclear cell, as well as a few polymorphs and mixed bacterial flora (pharyngeal contaminants).



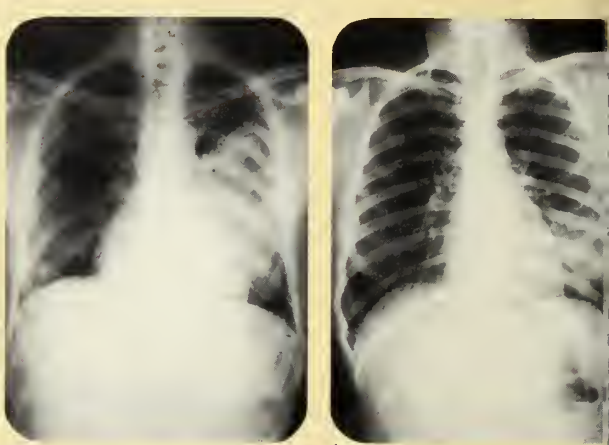
a b

Mycoplasmal or viral?

Differentiation between mycoplasmal and viral pneumonias may be impossible in the acute stage.

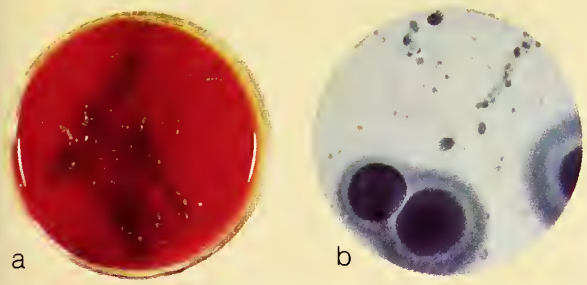
Serologic testing and culture methods for *Mycoplasma pneumoniae* are complex and time-consuming, taking as long as two weeks after obtaining samples. The sensitivity and specificity o the test for cold agglutinins have been questioned. The complement-fixing antibody test may reflect previous infection. Furthermore, facilities for culturi *M. pneumoniae* are not widely available.[3]

If treatment is to be initiated, therefore, it may b necessary to start on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.[1-3] In reachir such a diagnosis, the physician relies on clinical judgment, considering such factors as the age of th patient and the history of exposure. For example, *Mycoplasma pneumoniae* is considered the most common cause of pneumonia among ambulatory patients aged 20 to 35.[1]



a b

Chest x-rays of patients with (a) pneumococcal pneumonia—classically heavy, extensive infiltration of left lung; (b) mycoplasmal pneumonia—mild infiltrate confined to left lower lobe. Roentgenography usually does not help in differential diagnosis, since both types of pneumonias may present with a wide spectrum of x-ray as well as clinical findings.



(a) Distinct mucoid colonies of type 3 pneumococci *(Streptococcus pneumoniae)* on sheep blood agar showing greenish discoloration (alpha-hemolysis) of medium. (b) Typical "fried-egg" colonies of *Mycoplasma pneumoniae* consisting of dense central core with lighter periphery. Cultural and serologic methods for detecting *M. pneumoniae* are complex, time-consuming, and not widely available.

Expectant therapy

the patient with a presumptive diagnosis of ycoplasmal pneumonia or bacterial pneumonia, it ay be desirable to initiate antibiotic therapy before ılture and sensitivity results are available.

A course of erythromycin or tetracycline is nsidered effective in the treatment of mycoplasmal neumonia to help speed the clearing of infiltrate and orten the duration of symptoms.[1,3] In pneumococcal neumonia, erythromycin is an effective alternative to enicillin, the drug of choice. A recent report, based n data from 200 hospitals of 100 beds or more, found 3% of *S. pneumoniae* sensitive *in vitro* to ythromycin.[4]

Among these therapeutic agents, only ythromycin provides effective coverage of both ycoplasma *pneumoniae* and *S. pneumoniae*. The enicillins are not effective against *Mycoplasma,* and *pneumoniae* has shown a relatively high incidence resistance to tetracycline.

When erythromycin is selected for therapy, Mycin (erythromycin enteric-coated tablets, Upjohn) a good choice. E-Mycin is administered and bsorbed as active erythromycin base, and may be ken q.i.d., q 6h, or b.i.d., immediately after meals or etween meals. Thus, patients can use mealtimes to elp them remember their medication. The enteric oating on E-Mycin tablets helps ensure efficient bsorption in the intestinal tract, and bioavailability udies show that E-Mycin can be expected to roduce predictable, acceptable blood levels. The w cost of E-Mycin helps assure economical therapy.

E-Mycin rarely causes serious side effects and is ot associated with liver toxicity.* The most frequent de effects are upper gastrointestinal, such as bdominal cramping and discomfort, and are dose-elated. Nausea, vomiting, and diarrhea occur frequently with usual oral doses. Serious allergic eactions, including anaphylaxis, have rarely been eported.

se cautiously in patients with severe liver impairment.

EFERENCES: 1. Chusid EL, Dalrymple W, Holloway WJ, et al: Managing the infectious neumonias. *Patient Care* 9:122-167, 1975. 2. The occasional might of mycoplasma. *nergency Med* 7:82, 85, 1975. 3. Stevens DA: Viral and Mycoplasma pneumonias. *ostgrad Med* 55:81-86, 1974. 4. Data source: PMR Bacteriologic Report, Winter Series 1975-1976. Data are a compilation of laboratory reports submitted during December 1975 and January and February 1976 by 200 acute care hospitals of 100 beds or more.

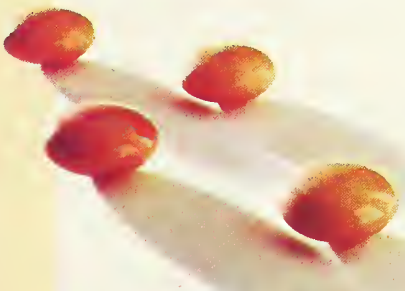
Please turn page for brief summary of prescribing information.

Summary

Because pneumonias may be difficult to differentiate at the outset, treatment is often initiated before a causal diagnosis is made. However, readily available diagnostic criteria occasionally allow early differentiation between bacterial and nonbacterial pneumonias. When the diagnosis appears to be nonbacterial pneumonia, further differentiation between mycoplasmal pneumonia and viral pneumonia is more complex and time-consuming. Therefore, therapy is often initiated on the basis of a *presumptive* diagnosis of mycoplasmal pneumonia.

Erythromycin is an effective antibiotic against *Mycoplasma pneumoniae, Streptococcus pneumoniae,*† and *Streptococcus pyogenes.*† E-Mycin (erythromycin enteric-coated tablets, Upjohn) is administered and well absorbed as the active base, may be taken immediately after meals or between meals, and is essentially nontoxic.

†Although penicillin remains the drug of choice against these organisms, erythromycin is an effective alternative.



E-Mycin® 250 mg

erythromycin enteric-coated tablets, Upjohn

wide-ranging usefulness in pneumonia*

*Mild to moderately severe, due to susceptible organisms.

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Wide-ranging usefulness in pneumonia*

E-Mycin® 250 mg

erythromycin enteric-coated tablets, Upjohn

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- For mild to moderately severe infections due to susceptible organisms that commonly invade the respiratory tract
- Essentially nontoxic (see Precautions and Adverse Reactions below)
- Documented bioavailability
- May be taken immediately after meals or between meals
- Active base formula produces predictable blood levels
- Formulated for quality...priced for economy

E-MYCIN® TABLETS — 250 mg — For Oral Administration (erythromycin enteric-coated tablets, Upjohn)

E-Mycin Tablets are specially coated to protect the contents from the inactivating effects of gastric acidity and to permit efficient absorption when administered either immediately after meals or when given between meals on an empty stomach.

Indications: *Streptococcus pyogenes (group A beta-hemolytic streptococci):* Upper and lower respiratory tract, skin, and soft-tissue infections of mild to moderate severity. Parenteral benzathine penicillin G is considered by the American Heart Association to be the drug of choice in the treatment and prevention of streptococcal pharyngitis and in long-term prophylaxis of rheumatic fever. When oral medication is necessary (because the parenteral route is contraindicated) or if there is known allergy to penicillin, the following recommendations made by the American Heart Association apply: 1) Oral penicillin G or V (where no allergy exists)—This is the drug of choice. Give for a minimum of 10 days; 2) Erythromycin—Give for a minimum of 10 days. A few strains of streptococci resistant to erythromycin have been reported.

Alpha-hemolytic streptococci (viridans group): Short-term prophylaxis against bacterial endocarditis prior to dental or other operative procedures in patients with a history of rheumatic fever or congenital heart disease who are hypersensitive to penicillin. (Erythromycin is not suitable prior to genitourinary surgery where the organisms likely to lead to bacteremia are gram-negative bacilli or the enterococcus group of streptococci.)

Staphylococcus aureus: Acute infections of skin and soft tissue of mild to moderate severity. Resistance may develop during treatment.

Diplococcus pneumoniae: Upper respiratory tract infections (eg, otitis media, pharyngitis) and lower respiratory tract infections (eg, pneumonia) of mild to moderate degree.

Mycoplasma pneumoniae (Eaton agent, PPLO): In the treatment of primary atypical pneumonia, when due to this organism.

Treponema pallidum: Infections due to this organism.

Corynebacterium diphtheriae and *Corynebacterium minutissimum:* As an adjunct to antitoxin, to prevent establishment of carriers, and to eradicate the organism in carriers. In the treatment of erythrasma.

Entamoeba histolytica: In the treatment of intestinal amebiasis only. Extraenteric amebiasis requires treatment with other agents.

Listeria monocytogenes: Infections due to this organism.

Contraindication: Contraindicated in patients with known hypersensitivity to erythromycin.

Warning: Safety for use in pregnancy has not been established.

Precautions: Erythromycin is principally excreted by the liver. Caution should be exercised in administering the antibiotic to patients with impaired hepatic function. Surgical procedures should be performed when indicated.

Adverse reactions: The most frequent side effects of erythromycin preparations are gastrointestinal, such as abdominal cramping and discomfort, and are dose-related. Nausea, vomiting, and diarrhea occur infrequently with usual oral doses. During prolonged or repeated therapy, there is a possibility of overgrowth of nonsusceptible bacteria or fungi. If such infections occur, the drug should be discontinued and appropriate therapy instituted. Mild allergic reactions such as urticaria and other skin rashes have occurred. Serious allergic reactions, including anaphylaxis, have been reported.

Treatment of overdosage: The drug is virtually nontoxic, though some individuals may exhibit gastric intolerance to even therapeutic amounts. Allergic reactions associated with acute overdosage should be handled in the usual manner—that is, by the administration of adrenalin, corticosteroids, and antihistamines as indicated and the prompt elimination of unabsorbed drug in addition to all needed supportive measures.

How supplied: 250 mg enteric-coated tablets—in bottles of 100 and 500 tablets, and in unit-dose packages of 100 tablets. Caution: Federal law prohibits dispensing without prescription.

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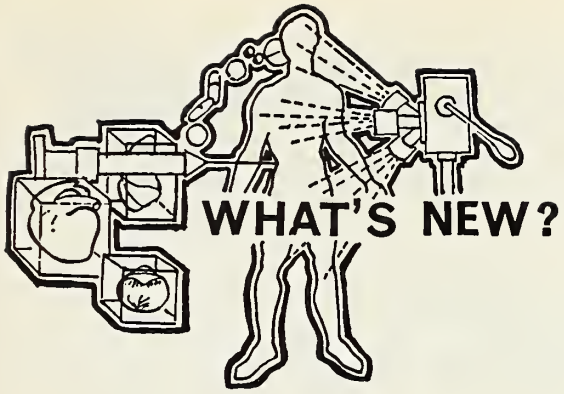
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*Mild to moderately severe, due to susceptible organisms



Burroughs Wellcome has eliminated the dosage of Actifed-0® Expectorant for infants under two years of age. Use of the preparation in infants under two years has been found to be inadvisable because of the possibility of overdosage of codeine.

* * *

The Ames Company has developed a new system, the "Tek-Chek® Synthetic Control Set for Dextrostix." It is designed to control the quality of results when testing for quantity of glucose in whole blood by the use of Dextrostix.

* * *

Parke-Davis is introducing a disposable surgical prep razor. Features a Schick Super Chromium blade and comes with a protective cover.

* * *

Searle Laboratories announce Lomotil® tablets packaged in flat, child-resistant, blister-sealed unit-of-use packs of 30.

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Parker Publishing has a new reference book titled "Medical Word Finder." Written by George Willefort, M.D., it is the second edition and has been completely updated. Recommended for medical secretaries. Includes a phonetic word list for those who don't know the spelling enough to locate the word. 490 pages, $12.95.

* * *

The Ames Company has issued a catalog to describe the comprehensive range of thyroid-testing products and services the company now has available. The "Ames Thyro System" catalog may be obtained free of charge by writing Miles Laboratories at Elkhart 46514.

* * *

The 3M Company announces three sizes of its Micropad brand Surgical Dressings. The sizes are 3 x 2, 3 x 4, and 3 x 8 inches. The 3 x 4 replaces the old 4 x 4. New packaging is see-through polyethylene. The Micropad dressing surface minimizes adherence.

* * *

Dell Publishing has released "Toddlers and Parents: A Declaration of Independence." Written by T. Berry Brazelton, M.D., previously the author of "Infants and Mothers," the new book is advice on the proper upbringing as applied to the young child—ages one through three being the last and only years in which parents can play a role in their child's development. $5.95.

* * *

Herculate Protective Fabrics announces a new fabric, 'LECTROLITE,® which is flameproof, antibacterial and self-deodorizing, also non-toxic and non-allergenic. Recommended for mattress ticking, covers for stretcher pads, pillows and traction bags. It satisfies critical O.R. safety standards. Resists soiling and cleans easily.

* * *

Purker Publishing announces the release of a new guidebook for public speakers. Title is "How Speakers Make People Laugh." Tells the speaker how to effectively illustrate, dramatize and sell ideas from the podium. 216 pages, $9.95.

* * *

The Elkhart Traveler Corporation, manufacturer of travel trailers and mini-motor homes has recently constructed a custom-built, 39-foot trailer containing x-ray equipment, which is to be used in conjunction with a companion trailer with facilities for EKG, hearing and lung testing, eye examination and laboratory studies. Mediscreen will use the trailers to provide mobile screening type medical examinations to industrial communities.

* * *

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Early surgical intervention, based on clinical findings, is mandatory.

Small Bowel Obstruction and Ileal Perforation: Complications of Uremia

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SEVERAL authors have reviewed the gastrointestinal complications of uremia in necropsy series of patients.[1-2] Only five patients, however, have been reported in the literature who were successfully treated operatively.[3,4,5] All five patients required surgical intervention for continuing gastrointestinal hemorrhage. This report concerns one patient with ileal perforation and one with intestinal obstruction who required operative management.

Case Presentation

Case 1

A 53-year-old white male was admitted to his local hospital with symptoms of nausea, anorexia, vomiting, diarrhea and colicky abdominal pain. He was febrile (102F) and laboratory studies revealed the following values: BUN of 49 mg%, creatinine, 2.5 mg% and 4+ proteinuria. Results of contrast studies of the upper gastrointestinal tract and colon were normal. He improved and was discharged with a diagnosis of chronic renal failure.

Two months later he was admitted to the Indiana University Medical Center (IUMC) with complaints of bilateral flank pain and morning nausea and vomiting. The most significant laboratory data were a BUN of 96 mg%; creatinine 6.7 mg%; hemoglobin 9.6 gm%; HCT 20%; creatinine clearance of 11 cc/min. In addition, urinalysis revealed specific gravity of 1.013, 3+ albumin and numerous red and white blood cells per high power field. Results of a renal arteriogram were normal. Closed renal biopsy and immune fluorescent studies supported the diagnosis of chronic glomerulonephritis of undetermined etiology. Because of continuing abdominal complaints, a repeat upper gastrointestinal and small bowel series, a barium enema and an oral cholecystogram were performed and results were normal. The patient improved clinically and was discharged on a 40 gm protein, 4 gm sodium and 1.5 gm potassium diet.

One month later he was readmitted to his local hospital complaining of lower abdominal cramping pain. Results of repeat contrast studies of the upper and lower gastrointestinal tract were unremarkable. The stool gualac test was positive for occult blood and the hematocrit value was 23%. When the patient's BUN and creatinine rose to 120 mg% and 11 mg% respectively and the urine output fell to 350 cc each 24 hours, he was referred to IUMC for hemodialysis.

The physical examination on admission revealed a blood pressure of 120/60, pulse 110 and regular, and temperature 98.6 F. The following laboratory results were recorded: Hemoglobin 8.2 gm%, HCT 24%, white blood cell count 10,500, serum sodium 128 mg%, potassium 4.8 mg%, chloride 99 mg%, CO_2 11, calcium 7.6 mg%, phosphorus 10.5 mg%, BUN 165 mg%, creatinine 11.7 mg%, serum amylase 60 units. Upright and supine radiographs of the abdomen

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FIGURE 1.
SMALL BOWEL at operation with circumferential partially obstructing lesions.

revealed distended loops of small bowel with multiple air fluid levels. During the next 12 hours, the patient complained frequently of increasing, generalized, crampy abdominal pain. Generalized abdominal tenderness and rebound were noted. An abdominal bruit was heard. A preoperative diagnosis of possible small bowel infarction and secondary peritonitis was made.

At laparotomy the proximal jejunum was moderately distended. The distal jejunum and proximal ileum contained numerous patchy areas which appeared to be necrotic. The largest of these lesions measured 10 cm in diameter. Several of these areas were circumferential and appeared to be causing a relative obstruction with proximal small bowel dilatation (Fig. 1). A segment of mid small bowel containing a majority of these lesions was resected. Histologic examination of the pathologic specimen revealed multiple mucosal ulcerations and hemorrhage. Several ulcers involved the entire circumference of the bowel (Fig. 2). The postoperative course was characterized by prolonged paralytic ileus of two weeks' duration. The patient's nutrition status was improved during this period by the use of central hyperalimentation.

Because of the patient's uncooperative behavior and psychopathic personality traits, he was not accepted for chronic hemodialysis. One month following his discharge from IUMC, he was readmitted to his local hospital, where he expired. Autopsy findings were consistent with uremic pericarditis, chronic glomerulonephritis and polyserositis. Multiple and diffuse submucosal hemorrhages and superficial ulcerations were noted in both the colon and small bowel. The surgical anastomosis was well healed and no perforations were observed.

Case 2

A 51-year-old chronic alcoholic was admitted to his local hospital with a diagnosis of dehydration. The BUN rose from 51 to 104 during the first two days of his hospitalization and he was referred to IUMC. On admission, blood pressure was 120/80, pulse 90 and regular, and he was afebrile. The physical examination was unremarkable. The hemoglobin was 8 gm%, sodium 125 mg%, potassium 5.5 mg%, chloride 87 mg%, BUN 127 mg%, uric acid 18.1 mg% and urinalysis revealed 3+ proteinuria and numerous red and white blood cells. Peritoneal dialysis was begun.

On the 13th hospital day the patient suffered a hypotensive episode resulting from upper gastrointestinal hemorrhage. Endoscopy revealed severe esophagitis and gastritis. The abdomen became distended with hypoactive bowel sounds. Dialysis fluid previously clear became brown and feculent in character.

The patient was immediately explored and at the time of laparotomy the peritoneal catheter was found to have perforated the ileum approximately 18 inches from the ileocecal valve. This perforation was closed with a two-layer inverting silk closure. On the 50th hospital day the patient became hypotensive following hemodialysis. During the ensuing 40 hours the patient deteriorated further, requiring ventilator support and an isoproterenal infusion. He died on the 52nd hospital day.

At postmortem examination the main finding was peritonitis. The distal ileum was involved in a process of pseudomembranous enterocolitis with spontaneous perforation. This perforation was some distance from the area of previous peritoneal catheter perforation.



FIGURE 2.
HISTOLOGIC SPECIMEN with mucosal and submucosal ulceration, transmural acute inflammatory response, mucosal hemorrhage and fibrin thrombosis and fibrinoid necrosis of blood vessels.

Discussion

Jaffe noted that the most common gastrointestinal lesion associated with uremia was submucosal hemorrhage occurring in 52.9% of cases. Edema was observed in 27.1%, while pseudomembranous and ulcerative changes were present in 19.8%.[1] Mason found no pathologic changes in the gut in 40.3% of cases in a postmortem series of 265 uremic patients. However, edema occurred in 18.9% and hemorrhage in 21.1%.[2] The incidence of ulcerations was similar to that of Jaffe's (19.6%). Jaffe and Laing point out that a majority of these lesions are found in the distal small bowel and ascending colon.[1]

Etiology

Since the late 1800s many authors have speculated about the etiology of these lesions. In 1859 Treitz proposed that they were the result of the adverse effects of ammonia and carbonic acid, formed from intraluminal urea, on the intestinal mucosa.[6] Hlava stressed the pathologic significance of small vessel thrombosis as a causal factor; while Mathieu and Roux believed bacterial toxins were responsible for the intestinal alterations.[7,8] Pineau proposed a combination of factors including changes in blood vessels, irritation of perivascular nerves and increased blood pressure.[9] Jaffe and Laing's early attempts at explaining the pathologic changes in the gastrointestinal tract were based on anatomical findings. In a review of 136 cases of uremia, Jaffe and Laing noted a close anatomical relationship between the occurrence of hemorrhages and ulcerations. They speculated that the initial insult was hemorrhage that caused a separation of the mucosa from the submucosa. The action of bacteria and/or their toxins on this hemorrhagic tissue possibly resulted in necrosis and ulceration.[1]

It is difficult to explain the observed changes entirely on an initial vascular insult. In a recent review of 12 cases of uremic enterocolitis Thoroughman could not demonstrate vascular changes in all his cases.[5] Thirty-three percent of Jaffe's patients with ulcerations had no arteriolar changes.[1] Although hypertension was observed in 50% of Thoroughman's patients, the inconsistency of this finding in all cases suggests it may be a frequent incidental observation in this group of patients.[5]

Mason found no correlation between the degree of azotemia and the incidence of gastrointestinal complications.[2] Recent evidence, however, supports the theory that the pathogenesis of these lesions is related to urea or its byproduct, ammonia, which results from bacterial enzymatic breakdown.[10]

Davenport has observed that urea causes a back diffusion of hydrogen in Heidenhain pouches in dogs.[11] This suggests that urea must in some manner break the mucosal barrier.

Carter and Einheber have stressed the importance of intraluminal bacteria in causing uremic ulceration. In their study, conventional Fischer rats, when compared to germ-free Fischer rats, had a much higher incidence of cecal ulcers after bilateral nephrectomy.[12,13]

Recently McDermott has observed a reduction in cell proliferation in the intestinal crypts of uremic experimental animals.[14]

At present, one would have to conclude that the etiology of these lesions is multifactorial. The mucosal barrier of these patients (many of whom have preexisting disseminated cardiovascular disease) is probably damaged by intraluminal urea or ammonia. Further damage is probably the result of the synergistic action of bacteria, cytolytic action of urea and hemorrhage.

Clinical Course

The increasing use of hemodialysis and renal transplantation has dramatically extended the lives of thousands of patients with chronic renal failure. The salvage of these patients occasionally may require operative treatment of the secondary gastrointestinal complications of the uremic state. Clinically, however, the diagnosis of these ulcerative and obstructive lesions may be difficult.[5] Repeated contrast examinations of the upper gastrointestinal tract may be normal, even in the face of severe ulcerative lesions, as was noted in our first case report.

Conventional radiographic studies to determine the site of gastrointestinal hemorrhage have been unreliable in 20 to 30% of patients with hematemesis and in over 50% of patients who present with melena.[15] Behringer et al. have pointed out the high incidence of misdiagnosis in hemorrhaging patients.[16] In contrast, early endoscopic evaluation (failure rate 7-19%) and visceral angiography have increased the diagnostic accuracy in bleeding patients and made limited segmental resections possible.[15,16] In the uremic patient it may be anticipated that the bleeding site or sites may be even more difficult to find at operation or by conventional x-ray methods. Preoperative endoscopy and angiography are recommended in all bleeding uremic patients so as to increase the accuracy of diagnosis, which should result in more specific limited operations with lower morbidity and mortality.

Usually, the medical history and physical examination must be relied upon in making the correct preoperative diagnosis. The authors agree with Thoroughman that the triad of vague, generalized abdominal pain, ileus, and melena is highly suggestive of these lesions.[5] Surgeons have been reluctant in the past to operate on these patients.[5] This is perhaps understandable, since not only are most of these patients poor operative risks, but, in addition, the secondary effects of urea on cell replication and wound healing have been documented both clinically and experimentally. However, when symptoms are persistent, with ileus, inability to eat and continuing abdominal complaints and signs, surgical intervention is appropriate. If areas of extensive involvement are encountered at the time of operation, resection is prob-

ably the best policy. The spontaneous ileal perforation of our second case report supports the rationale of early and aggressive surgical management of these lesions. Although more difficult to manage in uremic patients, the use of parenteral hyperalimentation may be a helpful adjunctive postoperative modality, as was noted in one of the IUMC patients.

Summary

Partial intestinal obstruction, gastrointestinal hemorrhage, ileus and spontaneous ileal perforation are observed complications of uremia. Persistent abdominal pain, ileus and melena in the face of these symptoms is highly suggestive of uremic gastrointestinal complications. Barium contrast studies are usually of little help and the diagnosis must be made based on clinical findings. Aggressive surgical management is the best policy, considering the possible complications of hemorrhage, perforation and prolonged ileus.

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Orgasm Headaches

GEORGE N. LEWIS, M.D.
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ORGASM headaches are an unusual form of headache. They are severe and, at times, temporarily disabling. These headaches appear in men and women at the peak of orgasm or immediately afterwards.

Although the modern liberal attitude of sexuality encourages patients to be more open about their sex habits, the literature has few reports about orgasm headaches. Yet "Letters to the Editor" of *Medical Aspects of Human Sexuality* about orgasm headaches accentuates the need to know more about the pathophysiology and treatment of these headaches.[1-5] The five cases presented here show how puzzling this complaint can be.

Case 1

Case 1 was a 50-year-old black, married female. She had long been in good health. She had four children. Her only surgical history was a hysterectomy with an asymptomatic postoperative period, 10 years ago. Her occupation was domestic day-worker.

This woman's complaint was severe, excruciating headaches during the orgasm period of sexual intercourse for the last three months. They appeared only at the time of orgasm. Prior to having these headaches, frequency of sexual intercourse was three to four times a week. Because of the persistence of the headache, the frequency dropped to once or twice a week. According to the patient, all coitus was with her husband. She denied any extramarital affairs.

The patient stated that during the preorgasmic period there was no headache. At the moment of orgasm, a "starburst" type of headache appeared over her head. Getting up and walking about, rolling to either side, lowering her head off the pillow or kneeling on the floor did not affect the duration or character of the headache. These maneuvers were done to seek relief from her headache, because it was severe enough to cause her to scream with pain.

Physical examination revealed a moderately obese black female in excellent condition. She was cooperative and alert. Neurological and general physical examinations showed no abnormalities. The optic fundi revealed no papilledema or atrophy, nor any vascular changes.

The patient was admitted to the hospital. A lumbar puncture was performed. The opening pressure was 110 mm of water. She had normal dynamics and the protein was 35 mg%. The cell count was 0-1. Results of serological study were normal and the results of other laboratory work, including a blood count, sed rate, urinalysis and SMA 12 were within normal range. Chest, skull and cervical spine x-ray films showed no abnormalities; neither did the electroencephalogram and brain scan.

Upon release from the hospital the patient was given 15 mg of phenobarbital to take at bedtime. Two weeks later she reported that the medication did not help her. Dilantin, 100 mg, t.i.d., was prescribed. Two weeks later she reported that it, too, did not help her. She stopped taking any medication. She volunteered that she took two aspirin before coitus was begun to see if that would thwart the headache but that did not prove to be of any benefit. Three months later the headache disappeared.

Case 2

Case 2 was a 20-year-old white, unmarried female who complained of headache during orgasm. She had been well all her life. Her last examination by a physician was a school examination prior to going to a university, which she was still attending. One year prior to her visit she was started on birth control pills. She continued taking the pills until she broke off with her boyfriend, which was three months before her first office visit.

Two months prior to this visit she began having an affair with a married man. She did not resume any pills, as the man had had a vasectomy. The frequency of coitus was once a week. About one month after beginning this affair she noticed that she would have a headache at the point of orgasm. She had six or seven orgasms during one meeting with this man and the headache began gradually with the first orgasm, would disappear, recur and disappear with each succeeding orgasm. The intensity of the headache increased with each orgasm until she had to stop, because the headache caused her to scream with pain.

The headache appeared over the top of her head, in both temples, and remained there during the orgasmic period and then would slowly ease. The headache was de-

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scribed as a pounding type, "like the beating of my pulse." For relief, she clasped both temples of her head and pressed in with her fingers on the top of her head. No relief occurred.

This patient refused to be admitted to the hospital but consented to having tests done as an outpatient. Her chest x-rays, brain scan, electroencephalogram, skull film, cervical spine, blood pressure studies, blood chemistry, blood count and urinalysis were within normal range. Results of the T_3 plus T_4 tests were normal. The patient refused to have a lumbar puncture.

The patient was asked to return the day following any sexual experience, if possible. Three such visits were made. She was examined on each visit and all parameters of the physical examination, neurological and optic fundi examinations were normal.

The headache was explained to the patient as an orgasmic headache. She was advised to reduce the number of orgasms at one meeting so that the intensity of headache would not increase to disability.

Sedatives, tranquilizers, Dilantin and analgesics were given to the patient, with no effect. She volunteered that perhaps she was having these headaches because of the illicit love affair, although her conscience never bothered her.

The patient broke off with the married man and after several weeks resumed seeing her previous boyfriend. She had coitus with him. He used a condom as a contraceptive. The patient complained again of the same headaches. One month later she resumed using birth control pills. She continued to have the headaches.

The patient married the boyfriend and for a six-month period had headaches of the previously stated intensity. Her husband found a job elsewhere. They moved away and contact with this patient was lost.

Cases 3 and 4

Case 3 was a white male and Case 4 a white female who had been married to each other a short time. The husband was 44 years old and the wife was 29. It was a second marriage for both. They had been well for the past 10 to 15 years, except for a hernia repair on the man. The husband was an assembly line worker. The wife worked in an electronics plant.

Three months after they married they both began to experience orgasm headaches. While their orgasms did not necessarily coincide, each had a headache during orgasm. The husband indicated his headache was in the frontal area, both temples, and was a dull ache that left after 10 minutes. The wife's headache was in both temples and in the vertex of the head. Hers was more severe than her husband's and lasted as long as 15 minutes by the clock. No mention was made by either patient of any attempts to relieve the headache. Their frequency of coitus was about five times a week.

The wife stated that she never had these headaches before, during the previous marriage or in any premarital affairs she had. Each denied extramarital affairs. The man volunteered that he had never had a headache at any time during any type of sexual activity and this was strange and new. He wondered if he had caught something from his wife.

Complete physical and neurological examinations of both patients revealed no abnormalities. Both were normotensive. The optic fundi in both patients revealed no significant change. Serological tests for syphilis were performed and were normal.

These two patients continued to have headaches. They refused to have lumbar puncture but had EEGs, brain scan, skull films, chest and cervical spine x-rays, as well as blood chemistry studies. The tests were normal.

The headaches were discussed with both patients. They were told that these headaches would probably be short-lived.

After a four-month absence both reported that the headaches were gone. The man stated he would have just a mild twinge of a headache, occasionally.

A year later the husband and wife appeared separately in the office. The wife denied any further headache. She ascribed her previous headaches to a conflict between her stepson and herself. The stepson had moved in with the couple, uninvited, during the period she and her husband had the headaches. She felt that the stepson's moving out and the disappearance of the conflict coincided with her headaches' leaving. An interview with the husband contributed nothing.

Case 5

Case 5 was a 22-year-old white employed male who was recently discharged from the service. He complained of a severe headache over the occiput and vertex of his head associated with a mild rigidity of his neck. The previous night he had engaged in coitus with his girlfriend and had several orgasms. With the third orgasm there was a sudden onset of a severe bursting type pain at the top of his head and down the back of his neck. He had difficulty focusing his eyes and turning his head to either side. His girlfriend drove him home. The patient went to bed, took four aspirin to get relief and put an ice pack on the back of his neck. When he awakened in the morning his headache was less intense. He was able to move his head from side to side but had difficulty touching his chin to his chest. Now there was pain over his forehead.

The patient was alert and cooperative. Blood pressure was 180/84. Pulse was 80. Respirations were 18. His general physical examination revealed no abnormalities, except a slight stiffness of the neck on passive forward flexion. The neurological examination was normal in all modalities. The diagnosis of a subarachnoid hemorrhage was considered.

The patient was admitted to the hospital. A lumbar puncture was performed. The opening pressure was 120. The fluid was clear. The dynamics were normal. Protein was 28. The cell count was 0-1. The results of a serological test for syphilis were normal. Results of tests performed for immunoglobulins were normal, as were skull x-rays, brain scan, chest film and cervical spine films. An electroencephalogram and the blood chemistry were normal.

The headache subsided after 24 hours, leaving the patient symptom-free. He was released from the hospital and he returned to work. One week later he came to the office and stated that during that week he had coitus three or four times a night, and each experience was associated with a headache of the same intensity as before. However, the headaches would disappear after sleeping for an hour and he was symptom-free afterwards. He was not seen again.

Discussion

Orgasm headache may be throbbing, bursting or explosive in nature. It may appear anywhere on the head and radiate in any direction. The application of pressure to the head (Case 2) gave no relief and change in position of the head during or shortly after orgasm had no effect (Case 1). In contrast, early in migraine attacks and in some tension headaches, hand pressure to the head can sometimes alleviate the pain temporarily. An inquiry of this author's other patients with migraine attacks revealed no attacks of orgasm headache. A migraine headache is not intensified during orgasm, but sometimes becomes worse if the head is lowered or moved from side to side during coitus and orgasm. Orgasm pain yields to no treatment, although the use of ergotamine compounds prior to engaging in intercourse has been suggested.[2]

Case 2 in this author's series had orgasm headaches both while taking and not taking birth control pills. In the Paulson and Klawans series,[6] one patient's headaches disappeared after she stopped taking birth control pills. This patient had no history of migraine but her mother and sister did. Another patient who had a history of migraine was able to prevent her orgasm headache by taking Bellergal one hour before intercourse. A male patient was treated with propanolol, diphenylhydantoin and diazepam with no success.

Regardless of the prophylactic and therapeutic treatment, the patients in this author's series obtained no relief. Phenobarbital, diphenylhydantoin, diazepam, Bellergal, Fiorinal, aspirin and a phenobarbital and belladonna combination were given daily, four times a day. Propanolol was not used.

The longest duration of pain was 24 hours (Case 5) in the cases presented here and "several hours" in the Paulson and Klawans series.[6] Case 5 raises the suspicion that the headache may be due to a small vascular abnormality. None of the five cases had any hypertension, but Paulson and Klawans had one case with a blood pressure of 160/95.

What causes these headaches? The evidence available now does not indict any particular mechanisms.[1-7] The author's five cases were people who were willing and active partners in sexual activity. Each patient enjoyed intercourse and had no reservations about engaging in such activity.

The Paulson and Klawans series had four patients with a family history of migraine and five patients who themselves had migraine attacks. In this author's series, none had migraine or a family history of it. While headaches can occur with exercise, particularly when excessive, the present series of patients denied any such occurrence.

Paulson and Klawans believe that the orgasm headache in the 14 cases they reported is not of psychogenic origin. They concluded that these headaches were not a physiological or psychological threat to the sufferer and ascribe orgasm headaches to a pathophysiological course; three of their cases originated from low spinal fluid pressure; the remaining eleven were thought to have a vascular basis.[6]

Psychic stress arising from illicit intercourse (Case 2) or emotional situations between partners or within the family (Case 4) could be a causc of the headache. A review of this author's office patients who admit to illicit coitus has not turned up other cases of orgasm headaches.

There is no evidence for an allergic basis of orgasm headache. Whether orgasm headache is due to neurohumoral factors, vasoconstriction or vasodilatation, metabolites from muscular contractions or prostaglandins has yet to be proven.[6] The prophylactic and therapeutic measures have varied and success of both has generally been poor.

The actual number of patients with headaches appearing during sexual activity is low.[6] A benign course of orgasm headaches appears to be characteristic, as demonstrated by the five cases presented here and those of Paulson and Klawans.[6] However, physicians confronted with patients who complain of severe headache during intercourse must always first consider structural lesions within the cranium. Spinal fluid studied and other neurological parameters, including the EMI scan,[8] would rule out these disorders.

Summary

Five cases of headache appearing at orgasm or immediately thereafter are presented. These headaches appeared in both sexes and involved people who were active and willing partners in coitus. Despite the pain, each patient enjoyed sexual activity. These people had been engaging in sexual activity long before the appearance of their orgasm headaches. The period of having headaches appeared suddenly and, in general, disappeared almost as suddenly, with no explanation and no residual effect. The character of the headache may resemble that of migraine, subarachnoid hemorrhage or other headaches. Orgasm headaches have not responded to the treatments employed. The cause in un-

known. Medical and neurological studies revealed no abnormalities in these patients.

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Management of Congenital Heart Disease in Infancy

CONGENITAL heart disease is a common congenital malformation occuring eight times in each 1,000 live births. One fourth of these cases are life-threatening during the first few weeks of life and require urgent transfer to a facility specializing in the diagnosis and treatment of congenital heart disease. The remainder require evaluation before one year of age. Successful conservative or surgical management is possible in almost all types of cardiac defects. A satisfactory long term result in each case depends on (1) early referral, (2) prompt specific diagnosis, (3) appropriate medical treatment, (4) surgical treatment, if indicated, and (5) early diagnosis and treatment of complications.

Early Referral

One fourth of cases will develop cyanosis and/or dyspnea during the first few weeks of life. Congenital heart disease should always be included in the differential diagnosis of infants with these symptoms. The presence of a murmur, hepatomegaly, cardiomegaly on chest x-ray, or a low pO_2 which does not rise to normal in 100% oxygen is strongly suggestive of a cardiac etiology for these symptoms. Prematurity, a reticulogranular pattern on chest x-ray, absence of a murmur and a rise in pO_2 to a normal level upon administration of 100% oxygen is against, but does not exclude, a cardiac etiology. Because certain defects, such as transposition of the great arteries, require intervention within 24 hours of discovery, prompt referral is necessary when congenital heart disease is strongly suspected.

Infants without the symptoms of cyanosis and/or dyspnea but with such findings as murmur, decreased femoral pulses or cardiomegaly on chest x-ray should be referred soon after discovery of these findings.

Occasionally, an infant thought to have a small ventricular septal defect will, in fact, have tetralogy of Fallot. The development of hypoxic symptoms can be anticipated in such cases. It is well known that some ventricular septal defects may close spontaneously and the murmur will become inaudible. Occasionally, the reduction in murmur intensity indicates the development of pulmonary hypertension and is actually an ominous finding. It is, therefore, important that a patient thought to have only a small VSD should undergo early evaluation.

Prompt Specific Diagnosis

The history and physical examination, including a careful evaluation of heart sounds, murmurs and pulses, combined with the electrocardiogram and chest x-ray, will usually narrow the diagnosis to two or three major possibilities. Echocardiography has further refined the non-invasive diagnositic process.

Echocardiography is a procedure allowing evaluation of heart structure and function. A transducer is placed against the precordium and high frequency sound is transmitted while reflected sound is simultaneously received and recorded. Structure and function of much of the heart may be studied. Echocardiography is useful in the evaluation of infants in three ways: (1) separating cardiac from pulmonary and other non-cardiac diseases, (2) allowing non-invasive serial studies of premature infants with associated hyaline membrane disease and patent ductus arteriosus to determine if surgical ligation of the ductus should be performed, and (3) in helping to specifically diagnose a congenital cardiac defect. Echocardiographic examination allows evaluation of size and motion of the various cardiac chambers, presence or absence of cardiac valves and evaluation of valve motion, presence and motion of the ventricular septum and evaluation of contractility of the ventricles.

Usually, the ill, symptomatic infant requires catheterization combined with angiographic study to obtain specific quantitative anatomic and physiologic data on which to base recommendations for management, including possible surgery. In cases of transposition of the great arteries, the catheterization is therapeutic as well as diagnostic.

Following the catheterization diagnosis of transposition, a balloon atrial septostomy is performed. In this procedure, a balloon catheter is inserted through the femoral

vein and directed across a small foraman ovale at the left atrium. The balloon is then filled with a radiopaque contrast medium and abruptly pulled through the atrial septum to the right atrium, creating a tear which allows better mixing of blood within the heart and an improvement in arterial oxygenation.

Institution of Medical Treatment

Medical treatment of congenital heart disease in infancy consists primarily of pharmacologic treatment of congestive heart failure and specific and supportive treatment for such complications as pneumonia, pulmonary atelectasis, derangement of acid-base and electrolyte balance and respiratory insufficiency. Cyanosis on a cardiac basis is usually helped only marginally by oxygen administration, but even such marginal improvement may be of importance.

Pharmacologic treatment of congestive heart failure in infants commonly consists of initial administration of oral Elixir of Lanoxin 0.060 mg/kg in four divided doses given over a 24-hour period followed by daily administration of 0.008 mg/kg twice daily. Furosemide is the usual diuretic and is administered at a dose of 1.0 mg/kg and may be given on a one time basis or as frequently as twice daily, as necessary.

Surgical Treatment

Conservative management, including drug treatment, may control symptoms of the infant with cardiac disease and allow postponement of surgery beyond the newborn period. However, even with aggressive medical management, many infants will require palliative or corrective procedures during the first six months of life. Several common cardiac defects will be reviewed in regard to indications for surgery, choice of operative procedure, operative mortality and late results of surgery.

Coarctation may result in heart failure during early infancy. Twenty percent of patients will present during infancy and 80% will be referred because of hypertension, murmur and absent femoral pulses at a later age. The symptomatic infant usually reveals, on x-ray, signs of both right and left heart failure, absent femoral pulses and cardiomegaly and pulmonary vascular congestion. A trial of medical management is indicated and some patients will become asymptomatic. However, many patients, especially those with associated defects, will require surgical correction. The operative mortality in uncomplicated coarctation in infancy is about 10%. A disadvantage of early coarctation repair is the possibility of re-stenosis at the coarctation repair site, which occurs in about 10-20% of patients. The long term postoperative results are good, although there is a tendency toward persistent hypertension, even when the obstruction is completely relieved.

Patent ductus arteriosus is another congenital defect frequently presenting in infancy. PDA may occur as an isolated lesion or in association with other congenital defects such as ventricular septal defect or coarctation of the aorta. Our present experience indicates that patent ductus arteriosus is most commonly seen in association with prematurity and hyaline membrane disease. Frequently, during the first 1-2 weeks of hospitalization, a continuous murmur suggestive of a patent ductus arteriosus is noted. If the shunt through the patent ductus is large, bounding pulses can be palpated. At this time a determination must be made as to whether the ductus is contributing sufficiently to the morbidity of the patient to necessitate surgical intervention. In addition to the usual evaluation, including signs of left and right heart failure, increasing cardiomegaly on x-ray and electrocardiographic evidence of left ventricular hypertrophy, echocardiographic evaluation has become very important. Patent ductus arteriosus results in shunting into the pulmonary artery and increased pulmonary flow. The increased pulmonary venous return results in dilatation of the left atrium. The echocardiographic evaluation in patent ductus arteriosus is based primarily on determination of left atrial size. The left atrial dimension in millimeters may be determined and compared to normal values. The left atrial dimension can be related to the aortic root dimension. In addition, serial determinations of left atrial dimension will reveal whether increasing left atrial dilatation is occuring. If clinical, x-ray and echocardiographic evaluation suggest that a moderate-to-large patent ductus arteriosus is present in a patient with hyaline membrane disease who is doing poorly, surgical ligation of the patent ductus is recommended. No infant is considered too small to undergo this surgery if it is needed. The operative results are primarily determined by the severity of the associated pulmonary disease.

Ventricular septal defect is the most commonly occuring congenital cardiac defect and is also the defect most commonly presenting with symptoms during infancy. Only large defects result in symptoms. The patient usually exhibits signs of respiratory distress related to increased pulmonary flow and pulmonary congestion. A prominent holosystolic precordial murmur is heard. The x-ray shows cardiomegaly and pulmonary congestion and the electrocardiogram most commonly shows biventricular hypertrophy. The patient with large ventricular septal defects usually develops very high pulmonary flow, pulmonary hypertension and congestive heart failure.

Medical management may be of some help, but frequently surgical intervention is necessary. There is general agreement that the operation of choice in any infant beyond one year of age is primary correction of the defect. In infants under six months of age it is somewhat controversial as to whether pulmonary banding should be performed, with total correction being deferred until approximately 3-4 years of age, or whether early primary closure should be done.

Pulmonary artery banding continues to be used at Riley Hospital in some small infants with large

ventricular septal defects who are very ill. It is clear that when the mortality and morbidity of early primary repair is equal to or only slightly greater than that of pulmonary artery banding, primary repair becomes the procedure of choice. With either the one-stage or two-stage approach, the long term results in patients undergoing surgery for large ventricular septal defects are excellent. Pulmonary artery banding currently carries an associated mortality of about 5-10%, early primary repair 10-15%, and late correction of ventricular septal defect about 5%. The late results in patients undergoing either one- or two-stage correction are excellent.

Tetralogy of Fallot is the most common cyanotic congenital cardiac defect requiring corrective surgery, and the third most common defect presenting with symptoms during infancy. The patient with tetralogy of Fallot is typically acyanotic at birth and has a murmur suggestive of a small ventricular defect. Cyanosis increases as the patient gets older and may become debilitating. Hypercyanotic spells occur and are characterized by rapid breathing, deepening cyanosis and partial or complete loss of consciousness.

After one year of age, primary correction of the defect is the surgical procedure of choice. The surgical approach under one year of age remains, as in ventricular septal defect, a matter of controversy. It remains our practice to perform a systemic to pulmonary artery anastomosis (such as a Blalock-Taussig shunt) in the very small, symptomatic patient with tetralogy of Fallot. If the patient is approaching one year of age at the time surgical intervention is required, total correction is the procedure of choice.

The mortality of surgery during the first year of life for tetralogy of Fallot is approximately 10%. If surgery can be deferred and correction undertaken at 3-5 years of age, the surgical mortality drops to about 5%.

About half the patients undergoing tetralogy of Fallot surgery require a patch which is placed across the right ventricular tract. Pulmonary insufficiency can be expected in these cases. Long term results in patients undergoing total correction for tetralogy of Fallot, especially in instances where a right ventricular outflow patch has been used, is uncertain. Early postoperative results and follow-up data obtained during the first 1-2 decades following surgery indicate that the general results can be considered excellent.

Transposition of the great arteries is the cyanotic congenital cardiac defect presenting most frequently during infancy. Affected infants are noted to become cyanotic during the first one or two days of life and are promptly referred to a diagnostic and surgical center where cardiac catheterization is done to confirm the diagnosis. As previously described, balloon atrial septostomy is then performed. Even after a relatively satisfactory balloon atrial septostomy, the patient still remains cyanotic. Further surgical intervention usually is indicated by one year of age.

At this time, total correction may be undertaken utilizing cardiopulmonary bypass. The Mustard operation is most often used. This operation consists of excision of the atrial septum and insertion of a pericardial or dacron baffle so that the caval blood is directed to the left ventricle and pulmonary venous blood is directed to the right ventricle. Approximately 80% of transposition patients survive long enough to undergo the Mustard procedure. The operative mortality of the Mustard procedure is 10-15%. Of those surviving the Mustard procedure, approximately one fourth will have serious complications, such as difficulty with rhythm, or obstruction to pulmonary or systemic venous return.

Less common defects, such as pulmonary atresia with hypoplastic right ventricle, tricuspid atresia, persistent truncus arteriosus and total anomalous pulmonary venous drainage, are amenable to corrective or palliative surgery. Only patients with hypoplastic left heart syndrome and those with the complicating factor of severe pulmonary vascular obstructive disease are considered inoperable.

Complications

Prompt referral to a diagnostic and treatment center for complications of congenital heart disease is indicated if optimal recovery is to be achieved. In addition to the more common problems of congestive heart failure and pneumonia, the possibilities of subacute bacterial endocarditis (SBE), brain abscess and cerebrovascular accident must be kept in mind.

SBE should be suspected in any patient known to have congenital heart disease who has unexplained fever. Multiple blood cultures are required to confirm or exclude this diagnosis.

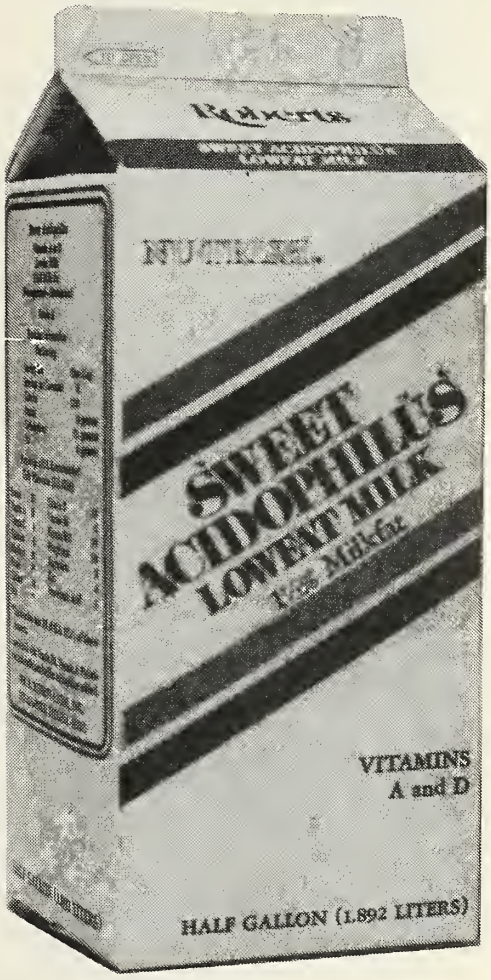
Brain abscess may occur in any patient with cyanotic congenital heart disease. Unexplained fever, headache, lethargy or neurological signs should alert the physician to this possibility. Skilled neurological examination, EEG and brain scan are required for diagnosis.

Cerebrovascular accident may be seen in cyanotic patients. It has been most common in patients with transposition of the great arteries. Neurological changes usually occur in the absence of fever. Brain abscess needs to be excluded.

Summary

Current diagnostic and therapeutic methods allow a high degree of success in the management of the infant with congenital heart disease. The primary care physician, by prompt initial referral and constant awareness of potential complications, can share equally with the pediatric cardiologist and cardiovascular surgeon in assuring that each child with congenital heart disease obtains optimal treatment. ◄

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Robert's Sweet Acidophilus low-fat milk is a drink for the whole family to enjoy daily — adults as well as children.

It is delicious, low-fat milk that is homogenized and pasteurized. But it has something special added, a natural culture which can aid the digestive systems of children and adults, which is why it is called "Sweet Acidophilus" milk. It is a milk with a sweet, fresh flavor to which has been added Lactobacillus acidophilus culture.

The raw acidophilus culture used in Robert's Sweet Acidophilus milk is an especially chosen strain. It can survive the acid conditions of the stomach and bile salts and does not affect the sweet, delicious taste of low-fat homogenized milk.

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Schedule for Upcoming NCME Programs

Here are the playing dates and upcoming programs to be distributed by The Network for Continuing Medical Education (NCME):

Nov. 15 through Nov. 28, 1976

"FIBEROPTIC BRONCHOSCOPY: ITS USES AND ADVANTAGES," with Bernard Marsh, M.D., associate professor of otolaryngology, Johns Hopkins University School of Medicine, and director, Broyles Bronchoscopic Clinic, Johns Hopkins Hospital, Baltimore.

"ALCOHOL INGESTION: ACUTE METABOLIC SYNDROMES," with Philip Felig, M.D., professor and vice-chairman, Department of Internal Medicine, and chief, Endocrinology Section, Yale-New Haven Hospital and Yale University School of Medicine, New Haven.

"CAT SCANNING: A NEW DIMENSION," with John R. Haaga, M.D., radiologist, Department of Radiology, The Cleveland Clinic, Cleveland.

Nov. 29 through Dec. 12, 1976

"THE SELECTIVE USES OF RADIOGRAPHS AND LABORATORY TESTS IN RHEUMATIC DISEASE," with Rodney Bluestone, M.B., M.R.C.P., chief, Rheumatology Section, Wadsworth VA Hospital, Los Angeles; and professor of medicine, UCLA School of Medicine, Los Angeles.

"THE FUNCTION OF PHAGOCYTES," with Thomas P. Stassel, M.D., chief of the medical oncology unit at Massachusetts General Hospital and associate professor of medicine at Harvard Medical School, Boston.

"BACTERIAL INFECTION AND DISORDERS OF THE WHITE CELL," with Thomas P. Stassel, M.D., chief of the medical oncology unit at Massachusetts General Hospital and associate professor of medicine at Harvard Medical School, Boston.

Dec. 13 through Dec. 26, 1976

"CARDIAC REHABILITATION: A STATUS REPORT," with Elliott M. Stein, M.D., assistant professor of medicine, New Jersey College of Medicine and Dentistry, and Chief of the Exercise Laboratory and the Cardiac Rehabilitation Program, Saint Michael's Medical Center, Newark.

"HOW TO ASSESS THE WHIPLASH INJURY," with John E. Stewart, M.D., clinical professor of orthopedic Surgery, University of Washington School of Medicine, Seattle.

(Pragram scheduling subject to change)



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LIBRIUM®
(chlordiazepoxide HCl)
5 mg, 10 mg, 25 mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Relief of anxiety and tension occurring alone or accompanying various disease states.

Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

***Usage in Pregnancy*: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Supplied: Librium® Capsules containing 5 mg, 10 mg or 25 mg chlordiazepoxide HCl. Libritabs® Tablets containing 5 mg, 10 mg or 25 mg chlordiazepoxide.

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system. It is used concomitantly with many primary medications, such as cardiac glycosides, antihypertensive agents, anticholinergics, diuretics, antacids and anticoagulants. It should be noted that variable effects on blood coagulation have been reported very rarely in patients receiving Librium and oral anticoagulants; however, a causal relationship has not been established clinically.

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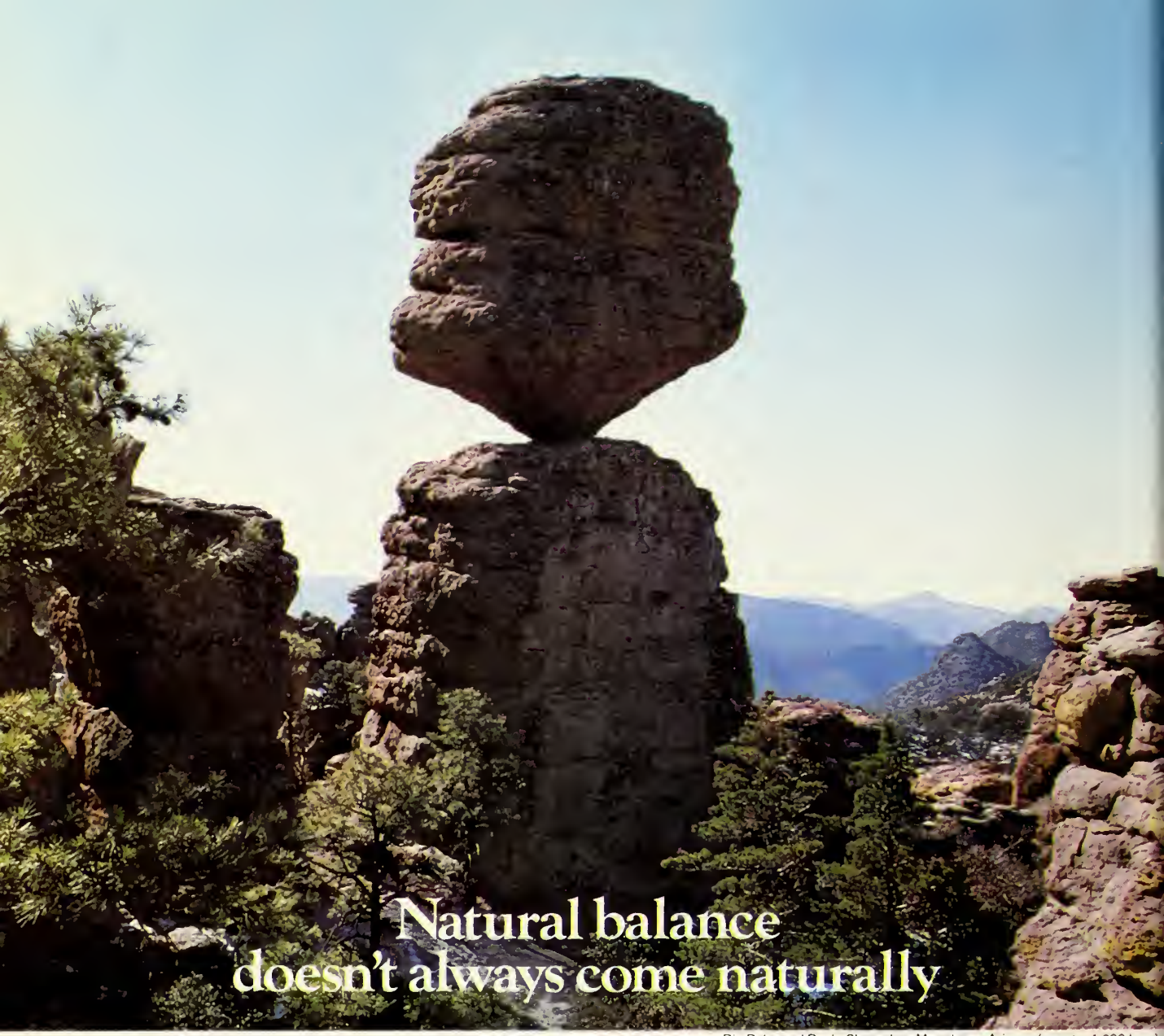
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Please see summary of product information on opposite page.



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■ **Most Widely Prescribed**—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

■ **Relief of Nausea and Vomiting**—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

■ **Dosage for Vertigo*** —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

ROERIG Pfizer
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Antivert®/25

(meclizine HCl) 25 mg. Tablets
for vertigo*

National Cancer Institute Background Statement on Laetrile

The National Cancer Institute has conducted several series of tests on Laetrile in the animal tumor systems used to screen drugs for anticancer activity. Laetrile is variously described as a form of Amygdalin, a nitriloside, Vitamin B_{17}, or 1- mandelo - nitrile - beta, glucuronide. Amygdalin is a cyanogenic glucoside that occurs in many plants. Supporters of the drug have used the names Laetrile and Amygdalin synonymously. The compound actually used in all tests at NCI and elsewhere (including clinical studies) has been Amygdalin. The compound was tested alone or in combination with an enzyme, beta-glucosidase. In each of the tests, summarized below, the compound failed to produce a reproducible antitumor effect.

1957: Amygdalin was tested with three transplanted mouse tumor systems used at the time by the NCI Cancer Chemotherapy National Service Center (CCNSC) to screen compounds for anticancer activity. Amygdalin produced no significant inhibition or growth of the carcinoma 775 or sarcoma 180 tumors, and produced no significant increase in the lifespan of mice with leukemia L1210 tumors.

1960: Material from a different source was tested against the same three mouse tumors. The compound failed to show antitumor activity.

1969: Amygdalin was tested alone and in combination with beta-glucosidase against leukemia L1210 in mice. Amygdalin was inactive against the tumor, alone and in combination with the enzyme. Toxic side effects increased when the drug and enzyme were given together.

1973: Amygdalin was tested alone and in combination with beta-glucosidase against Walker 256 carcinoma in rats and against the following 4-tumor mouse screen currently in use by NCI: Leukemia L1210, lymphoid leukemia P388, B16 melanoma and Lewis lung carcinoma. Amygdalin was completely inactive against the four tumors, alone or in combination with the enzyme.

1975: Amygdalin was tested alone and in combination with beta-glucosidase against three transplanted mouse tumors: lymphoid leukemia P388, Lewis lung carcinoma and Ridgway osteogenic sarcoma. In these tests, Amygdalin had no antitumor activity.

Tests of Amygdalin are continuing at the Memorial Sloan-Kettering Cancer Center, New York City, with spontaneous, naturally occurring mammary (breast) tumors in two strains of mice: Swiss and CD8F1 hybrid. To date, Amygdalin has shown no reproductible effect on either growth of the original tumors or development of subsequent metastases.

Scientists at the Memorial Sloan-Kettering Cancer Center are also testing the effects of Amygdalin against a spontaneous, naturally occurring leukemia in AKR mice.

The National Cancer Institute is conducting additional tests of Amygdalin against a metastatic mouse tumor, the Lewis lung carcinoma. The current tests are directed toward assessing the effect of Amygdalin on development of metastases from the tumor. Previous tests showed conclusively that Amygdalin did not inhibit growth of the primary tumor, nor did it reproducibly increase the lifespan of the mice.

Past NCI tests of Laetrile in many rodent tumor systems have failed to produce evidence of anticancer activity. Because there is no basis for predicting that Amygdalin might act against cancer in humans, the National Cancer Institute does not intend to test Amygdalin in cancer patients. Nevertheless, the National Cancer Institute is committed to pursuing any evidence that might provide a basis for clinical trials with cancer patients.

Laryngectomee Visitation Program

Over the past year, the Statewide Laryngectomee Committee organized by the American Cancer Society, Indiana Division, Inc., has been developing a laryngectomee visitation program for Marion County. This pilot program, which parallels the nationally recognized Reach To Recovery visitation program for mastectomees, has been named SPEAK UP FOR RECOVERY.

As of October 1976, seven laryngectomees who reside in Marion County are prepared to make patient visitations on the written request of a physician. Each volunteer visitor has (1) met strict speech, personal appearance and personality qualifications, (2) has been recommended for the program by his or her surgeon, and (3) successfully completed an eight-hour training course in technic and laryngectomee patient visitation.

To date, the Marion County program has provided support to over 50 laryngectomized patients. It is estimated that 75% of laryngectomy surgery patients were visited since the inception of the program, demonstrating physician acceptance and utilization of volunteers in the SPEAK UP FOR RECOVERY Program. Future program development will occur in Lafayette.

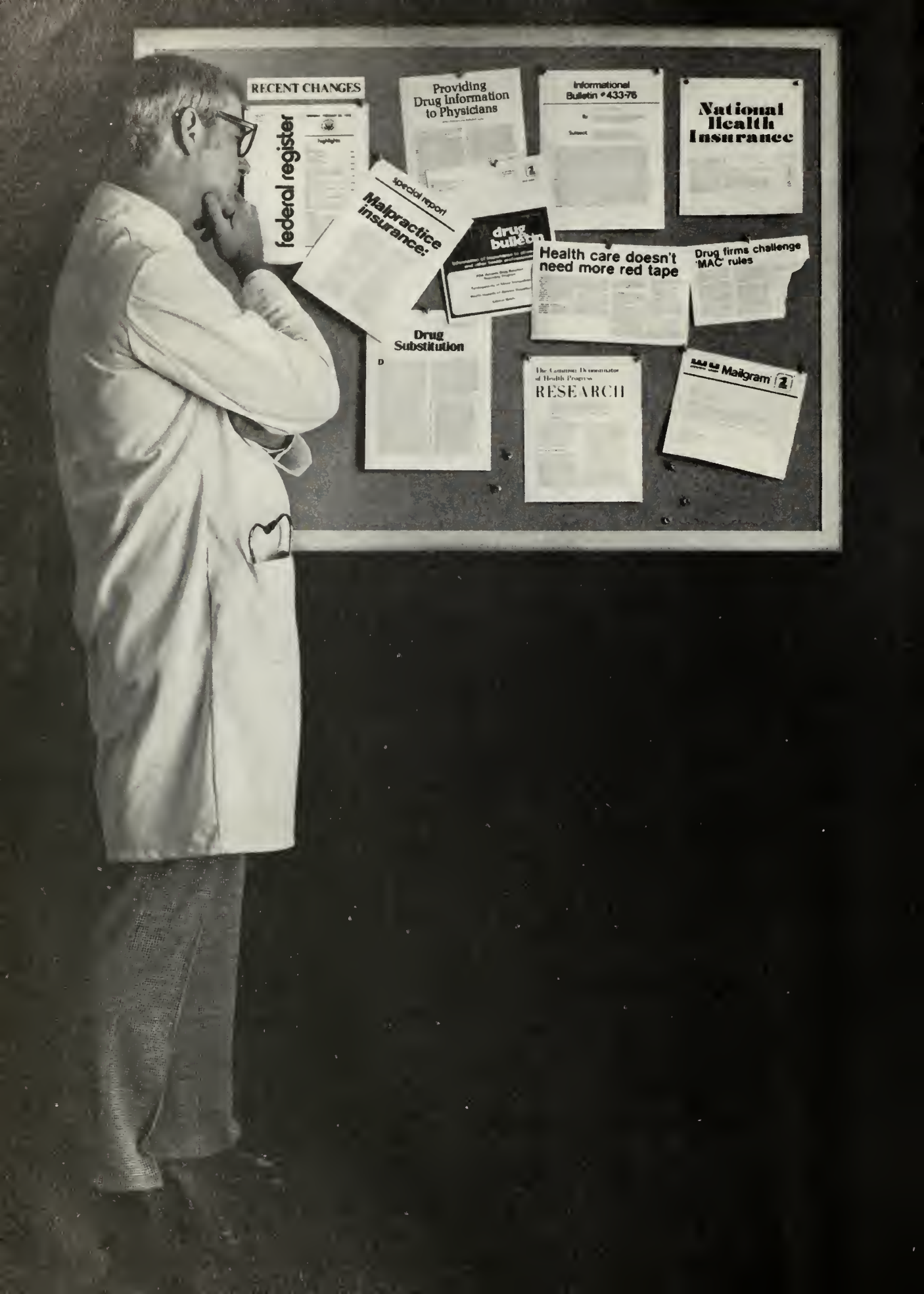
Any request for information regarding the program should be referred to the statewide chairman: Dr. Eric Blom, VA Hospital, 1481 W. 10th Street, Indianapolis 46202.

CANCER CORNER

New information from
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American Cancer Society, Inc.
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Every Physician's Office—A Cancer Detection Center

WILLIAM M. DUGAN, JR., M.D.
President, Indiana Division
American Cancer Society, Inc.


RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

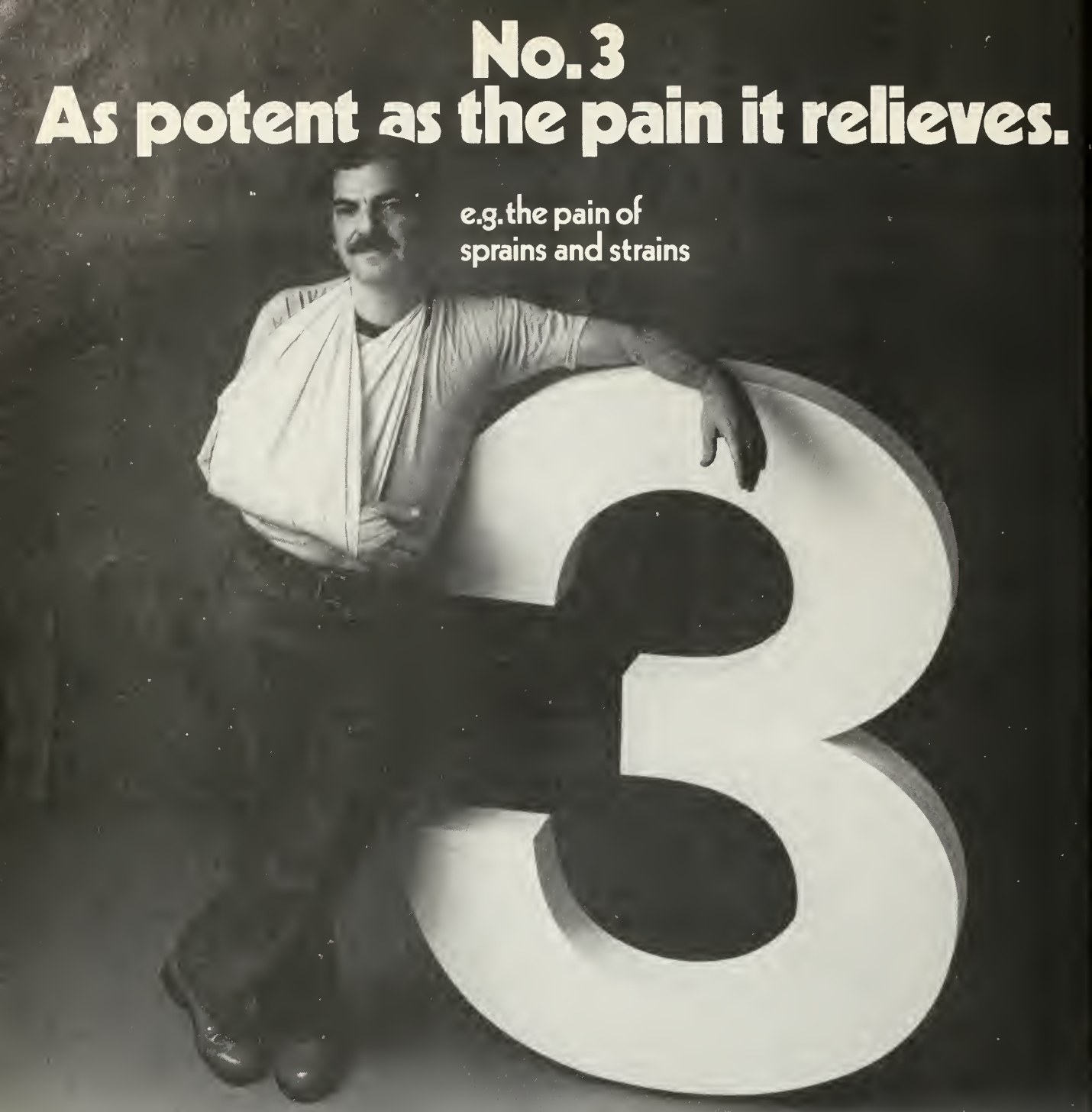
It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

No. 3
As potent as the pain it relieves.

e.g. the pain of
sprains and strains



NOT TOO LITTLE

- as potent as the pain you need to relieve in patients with fractures, sprains, strains, wounds, contusions, and the pain of surgical convalescence
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Caution: Drug Substitution Can Be Hazardous To Patient Health. Repeal Of Patient Protection Statutes Has Resulted In Therapeutic Failures

MALCOLM C. TODD, M.D.
Long Beach, Calif.

REACTING to pressure from consumer groups and self-styled government "reformers," state legislatures throughout the country have been considering proposals to repeal antisubstitution laws relating to prescription drugs. The forces behind this movement are under the misconception that drug substitution will lead to lower drug costs for patients.

New drug substitution laws already have been enacted in 19 states that permit pharmacists to substitute cheaper generics for brand name products. In most cases —but not all—some form of physician control is retained in theory. Physicians can prohibit substitution by noting "do not substitute," "dispense as written" or similar cautionary language on the prescription slip.

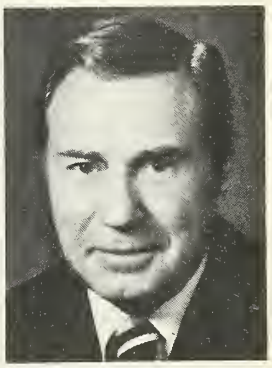
In fact, however, a physician's time is limited. He can, and often does, fail to make such required notations while writing a prescription. Under the new laws, the pharmacist often is required to substitute with the cheapest generic, but he is not required to notify the prescribing physician when a drug substitution is made.

Politicians practicing medicine —that's what drug substitution amounts to. Overzealous politicians "feeling the heat" when they are, in reality, tampering with the health and well-being of their constituents. Our patients.

The drug substitution cult is so vocal that legislative activity on this matter is expected in every one of the 31 states retaining antisubstitution statutes when legislatures convene again.

In the meantime, episodes of therapeutic failures as a result of unauthorized drug substitution are becoming more common. One such case involving superficial thrombophlebitis occurred in Michigan earlier this year. In a letter to a Michigan state senator, the attending physician blamed the incident on passage of a drug substitution law in 1974.

The physician related how a female patient who received a generic substitute from a pharmacist suffered (1) a relapse of the illness, (2) painful side effects, (3) the prospect of hospitalization, (4) increased medical expenses because of the failure of the substituted drug, and (5) additional productive time lost from work. All this because an inferior generic drug was substituted.



Treatment had to be extended for superficial thrombophlebitis and inflammation of the veins. The dangers associated with this clotting situation were obvious.

Arlidin was used to treat this patient. She was responding satisfactorily—until a prescription for the medication was filled at a different pharmacy. Several days after she began taking the new prescription, she visited her physician and reported severe discomfort that included headaches and burning and itching sensations.

Upon examination, her physician could find no source for the discomfort. When it was learned she was taking a new prescription, the physician asked her to bring it to his office. It was only after she returned with the prescription container that it was determined a generic substitution had been made. Nevertheless, the pharmacist had labeled the drug Arlidin. No request had been made by the patient for a generic substitute. Yet the Michigan

Dr. Todd is a practicing surgeon in Long Beach, California. He is past President of the American Medical Association and the California Medical Association. He is a graduate of the University of Illinois and the Northwestern University Medical School and is a professor of surgery at the University of California. In addition to his medical and educational activities, Dr. Todd has been a community leader in the Long Beach and Southern California areas for two decades.

law requires this action to take place.

This same physician also reported another patient whose heart condition suddenly was accompanied by additional pain. Suspicious that a substitute medication was dispensed, the physician's concern was proven correct upon examination of the medication. The patient's discomfort subsided after being returned to the exact drug product originally prescribed.

In California, where a law authorizing drug substitution was enacted last year, a patient described ulcer symptoms to his physician. He was advised to take antacid tablets and go on a bland diet. But a different type of antacid tablet was substituted for the brand specified by the physician.

About five days later, the patient returned to his physician with severe abdominal pains and distention. It was obvious, the physician reported, the patient was suffering from an intestinal obstruction.

Because of the increasing symptoms and the persistence of the obstruction, surgery was performed. Approximately 18 cm of the ileum were resected. Numerous radioopaque tablets were noticed when the ileum specimen was opened. At least 150 intact antacid tablets were removed.

Comparative tests were made. The antacid tablets that were substituted, and the ones the physician had specified, were placed in solution in separate beakers. The tablets specified by the doctor dissolved easily within 30 minutes; the tablets of the substituted type had not dissolved after four days.

Therapeutic failures involving drug substitution also have been reported at high levels of government. In the 1960s the White House dispensary substituted a generic product for a brand prescribed by a surgeon who had performed minor bladder surgery on the vice-president. The vice-president said that the medicine he was taking was tearing up his stomach.

The physician discovered the dispensary had substituted a different product than the one originally prescribed. When the vice-president was put back on the original drug he got over the discomfort.

Treating a hypertensive patient, a Detroit physician prescribed a drug containing a potassium supplement. However, when this patient received a similar hypertensive product, but without the supplement, the result was a dangerously low potassium level. Suffering severe abdominal pains, vomiting and other side effects, the patient was hospitalized. Some consideration was given to surgery, but laboratory tests confirmed that the lack of potassium was the cause of the problems. Recovery for this patient was directly related to the patient again receiving the proper medication. This "generic" substitution occurred even though the drug originally prescribed and the substitute were not even generically identical—only somewhat similar, but with a critical difference.

The medical community long has been aware of bioavailability problems with drugs that are considered to be the same chemically. There is a difference in therapeutic response; we in medicine know it. But we are doing a poor job of telling the public and the politicians about it.

Thirty-three of 36 companies manufacturing digoxin were found to be producing either superpotent or subpotent products. Too much digoxin administered to a heart patient could, of course, result in poisoning. Too little could do practically nothing to check the condition.

Like digoxin, the dosage definition of the anti-coagulant dicumarol is extremely critical. It is imperative that each version of the drug release the same amount of active ingredients. If too much is released, hemorrhaging takes place. If too little enters the body, the patient's heart condition can remain untreated. In one study there was a 300% difference in anticoagulant action among the various types of dicumarol tested.

Patients taking the oral antidiabetic agent tolbutamide in the United States (where it is manufactured by only one firm) have experienced serious problems in controlling the disease when their prescriptions were refilled in Canada where the product is made by different companies.

The delicate balance of dosage required for many life-saving and life-sustaining drugs is of critical importance. Affecting this balance are more than 30 major elements in the drug manufacturing process that can lead to unexpected and unusual responses in the body.

The growing concern over drug substitution among medical professionals is compounded by the entire subject of malpractice. Who is liable in therapeutic episodes involving a substituted drug? The physician? The pharmacist? Both? in most states, the question has not even been considered.

Responsible drug substitution already is practiced within the cooperative relationship between individual physician and pharmacist. And physicians are writing generic prescriptions every day—but only when they are comfortable about the quality and efficacy of the product.

New laws permitting drug substitution tend to drive a wedge between physician and pharmacist by promotion interchange without physician approval or knowledge. This is a serious interference with the traditional medical processes.

Drug substitution is not an issue that affects only the pharmacist. It concerns the physician and the integrity of medical practice. As physicians, we must organize to defeat ill-advised legislative substitution schemes, and to communicate the reasons for our opposition to government, to the communications media and to the people. ◄

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Guest Editorial

On Donating Organs

RECENTLY I had the chance to attend a workshop on organ donation. The need for more organs was obvious—especially for kidneys and eyes. But the organs aren't forthcoming. Why?

We see bumper stickers with "Transplant kidneys; don't bury them," and the message is clear and logical. But why isn't the gift of life or sight given more freely—when the advantages are so obvious?

Probably because of a literal interpretation of "resurrection of the body."

We don't want ourselves or our loved ones resurrected after death in an incomplete state—without eyes "the windows of the soul," for example. And so we hesitate and let a wonderful chance to help another human slip by. I know. I wrestle with my own fears about being resurrected or recreated incomplete. I understand how others feel.

I have to remind myself that the phrase "resurrection of the body" is a figure of speech the Apostle Paul used to tell us that in everlasting life we would retain our personhood; we wouldn't be lost as one tiny spirit in an infinite spirit, like a drop of water loses its identity when it's poured into a lake or ocean.

I don't think that Paul meant that the physical body we now have would be resurrected intact. But he was trying to define the undefinable—that there would be a life after death and what that life would be like. I think he did a good job of it. It's tough to talk about resurrection or life after death; Paul and others should be permitted to use a figure of speech or two.

Resurrection of the body was a problem for man even before Christianity came on the scene. Before Christ was born, the Pharisees argued for, and the Saducees argued against, the idea of resurrection of the body.

Christ came, lived, died and was resurrected; his followers say that they, too, will be resurrected. But just how isn't clear.

To many, the resurrection will truly be a literal resurrection of the body we now have. Look at the expense for embalming, sealer caskets, graves with good drainage—"The American Way of Death."

The avoidance of autopsies, organ donation and cremation is just another part of this primordial fear that grips most of us. We don't have to look far or think hard to see and feel the evidence for a belief in the literal resurrection of the body.

I have to wrestle with myself, and most of the time I'm convinced that donating my organs, an autopsy, and cremation are desirable for my body after I die. My thinking isn't free of some fear, though.

But what do others think?—**Richard J. Noveroske, M.D., Evansville.**

Editorial Notes . . .

The FDA Advisory Review Panel on Over-the-Counter Cold, Cough, Allergy, Brochodilator and Antiasthmatic Drug Products recommended that 14 ingredients now wholly or partially (dosage) limited to prescription use be sold directly to the public for self-treatment. The FDA accepted recommendations for 10: brompheniramine, clorpheniramine, methoxyphenamine, theophylline (three different salts), oxymetazoline, pseudoephedrine (two salts), and xylometazoline. Recommendations on OTC distribution for diphenhydramine, doxylamine, and promethazine were not accepted. FDA is deferring a decision on diphenhydramine as an OTC antitussive. Full details appeared in the Federal Register for Sept. 9. Comments will be accepted for 120 days.

Children of men who have suffered myocardial infarction before age 50 have significantly higher levels of blood cholesterol than children of a second group of fathers similar to the heart attack victims but with no history of heart trouble themselves. The elevated cholesterol levels were consistent in all age groups through 21 years old, and were not significantly different between boys and girls. The report is published in the August issue of *Pediatrics* by a group from University of Miami in Florida. ◄

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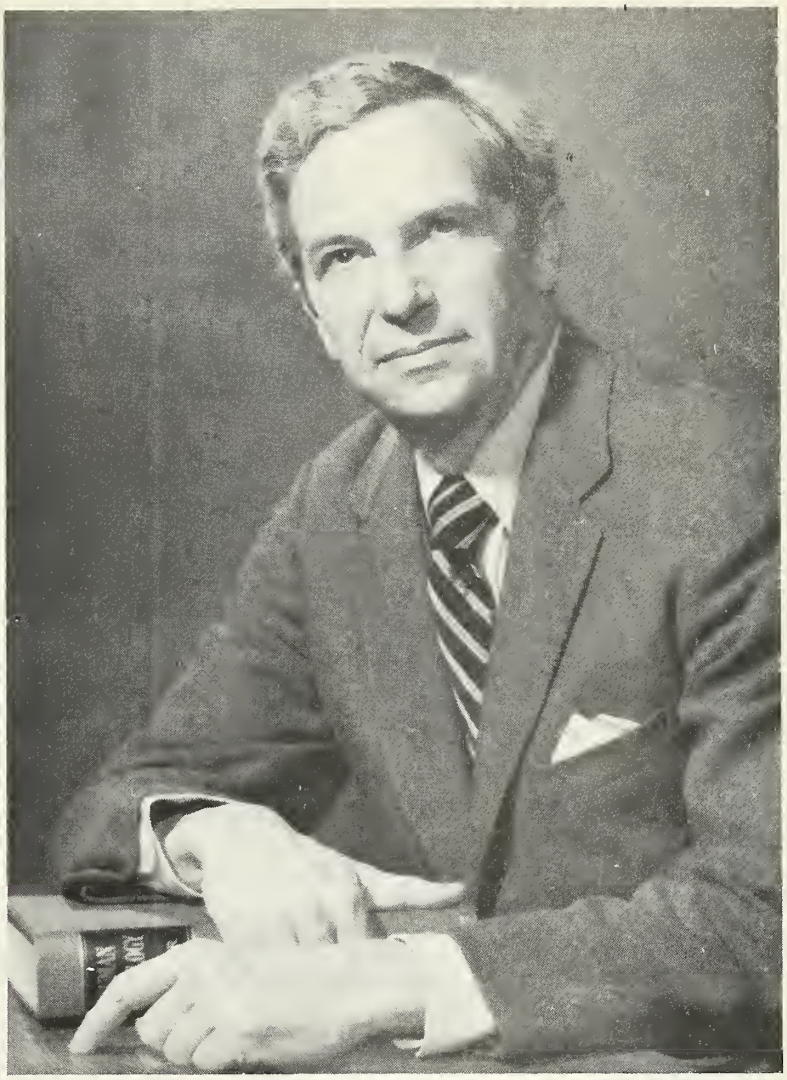
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3935 North Meridian Street
Indianapolis, Indiana 46208

JOHN W. BEELER, M.D.

President

Indiana State Medical Association

1976-77



Dr. John W. Beeler was installed as president of the Indiana State Medical Association during the recent Annual Convention.

Dr. Beeler, the son of Dr. Ray Beeler, was born in Indianapolis, July 2, 1921. He attended Wesleyan University in 1939 and earned a B.S. degree from Indiana University in 1942 and the M.D. degree from Indiana in 1944. His internship was served at the Philadelphia General Hospital. He was a Fellow in Radiology at the Mayo Foundation Graduate School and received an M.S. in radiology in 1950. He is certified by the American Board of Radiology and has practiced his specialty in Indianapolis since 1950.

He served in the Medical Corps of the United States Air Force from 1945 to 1947 and in the Medical Department of the United States Army in 1953 and 1954, with duty in Japan.

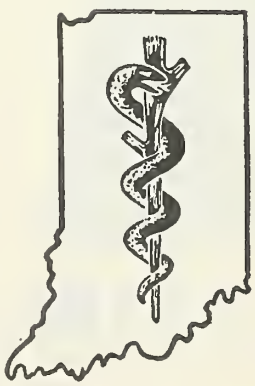
John is married—he and his wife Sally are the parents of three sons, Jack, Richard and Tom. When, and if he has time, he expresses his interest in horticulture, golf and tennis.

Dr. Beeler has been active in medical societies with service to the Marion County Medical Society for many years as a director. He was delegate to ISMA for many terms and was Speaker from 1973 to 1975.

He is Assistant Professor of Radiology at Indiana University School of Medicine, and serves in various official capacities at Wishard Memorial Hospital, Community Hospital, St. Vincent Hospital and Winona Memorial Hospital in Indianapolis and the Hancock County Hospital in Greenfield.

He is a member or Fellow of all the radiological societies, both state and national, and has performed yeoman service for these organizations as counselor, chancellor and president, in addition to chairman of Executive Committees of many.

Dr. Beeler has contributed greatly to the work of ISMA as a member of the Medical-Legal Review Committee, and as a Director of Blue Shield for many years.



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BOOK REVIEWS

A PATTERN OF HERBS

Meg Rutherford, Doubleday and Company, Inc., Garden City, N.Y., 1976; $2.95.

A Pattern of Herbs is the product of a collaborative effort, with the illustrator and writer being Meg Rutherford. It might well be termed the compleat herbalist.

Although many herbs have seen medicinal use over the centuries, perhaps their chief usefulness has been in cookery. Perhaps the Shakers were America's leading herbalists. They founded the country's first "pharmaceutical" company, which raised and sold herbs from their headquarters near Albany, N.Y. Perhaps more importantly, the Shakers, great cooks that they were, employed herbs extensively to spruce up their otherwise Spartan fare. More recently, herbs have been a God-send to people on restrictive diets, such as those low in sodium.

A Pattern of Herbs describes more than fifty herbs, with scale drawings of each plant to help identify it. The book tells where herbs are likely to grow, how to grow them and what to do with them when you have found them. There is an indispensable "kitchen summary" listing common foods and the herbs to use with them. There is a chapter on the medicinal uses of herbs, with customs, traditions and superstitions involving them. Recipes from a 1753 cookbook from "The Lady's Companion," London, add additional charm and usefulness to this altogether charming and useful little book. The book is paperback, profusely illustrated, and sells for $2.95.

W. D. SNIVELY, JR., M.D.
Evansville

HERESIES

Thomas Szasz, professor of psychiatry, State University of New York, Upstate Medical Center in Syracuse, Anchor Press/Doubleday, Garden City, N.Y., 1976; paperback original; 183 pages; $2.95.

This book is so much a presentation of heresies as it is a collection of paradoxes and paradoxical aphorisms developed on the basis of an heretical point of view or method of thought. This leads, of course, to some very unconventional, unorthodox and even "unscientific" conclusions, since nothing is "sacred" to this man except the dignity of the human spirit.

Although divided into chapters with titles such as: Marriage, Love, Ethics, Language, Punishment, Politics, Religion, Medicine, Drugs, Psychiatry and 19 others, there is not much unity, coherence and emphasis, except a recurring emphasis all through the book upon "drug abuse." For instance, a few quotes: "Drug abuse conference: people sitting around in smoke-filled rooms discussing the evils of marijuana." "Experts on drug abuse: merchants in mandate medical mendacities." "Question: When is prescribing a drug—officially recognized as a legitimate therapeutic agent—to a consenting patient suffering from an officially recognized illness not a treatment but a crime? Answer: When the disease is morphine addiction and the therapeutic agent is morphine." "Getting 'dangerous drugs' from a doctor is called 'drug treatment'; giving them to oneself is called 'drug abuse.' "

The author, a psychiatrist himself, is just as sarcastic in his numerous observations on that specialty. For instance, "Psychiatric nosology"—a dictionary of defamations disguised as diagnoses."

Paradoxes and such brilliancies aside, the real value of this work is as a study of metaphors as they affect our lives and conduct, and to have these oddities of the human condition called to our attention in intense capsule form will benefit the reader, heretic or no—especially if he is a doctor of medicine.

A. W. CAVINS, M.D.
Terre Haute

P.S. According to *Webster's Biographical Directory*, Szasz is pronounced Sahss.

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The Women's Auxiliary Reports to ISMA

Our State Leadership Conference was successfully held at the ISMA Building Tuesday, Sept. 14. New friendships were made and old friendships strengthened as doctors' wives joined together under their state leadership to further the cause of the medical profession in Indiana.



It was an all-day session, highlighted by our national first vice-president and membership chairman, Mrs. Ben H. Johnson, Jr.; Dr. Steven C. Beering, dean of the Indiana University School of Medicine; Mr. Donald Foy, ISMA executive director; Mr. Bob Sullivan, ISMA director of public relations, and ISMA auxiliary officers and chairmen.

Best of all, the state team spent a lot of time listening to the problems and suggestions from County Auxiliaries. The workshop was an interchange of information and it was not at all unusual to hear women in corridors exchanging ideas about how to help people.

County officers and chairmen went home with renewed inspiration and determination to share with their auxiliaries who are the heart of our organization.

Chloe A. Goldsmith

Chloe (Mrs. David A.) Goldsmith
President, ISMA Auxiliary

Postgraduate Courses Offered at Michigan

The University of Michigan announces the following postgraduate courses, all but one of which will be held at the Towsley Center in Ann Arbor:

Nov.	Target Audience	Title
23	Pathologists	Continuing Pathology Conference
Dec.		
1	Family Physicians	Cardiology for Family Physicians
3	Student Nurses	Basic Burn Care
1977		
Jan.		
24-28	Family Physicians	Family Practice Review
Feb.		
21-25	Emergency Physicians	Emergency Medicine
18-19	Respiratory Therapists	Respiratory Therapy
Mar.		
1	Pathologists	Continuing Pathology Conference
2-3	Pediatricians	Advances in Pediatrics
4	Student Nurses	Basic Burn Care
14-15	Surgeons	General Surgery Conference
21-25	Medical Technologists	Hematology for Medical Technologists
April		
4-29	Surgical Residents	Surgical Anatomical Review
5-6	Obstetricians, Gynecologists	Obstetrics and Gynecology Conference
18-22	Family Physicians	Family Practice Review
25	Social Workers	(not determined)
26-28	Family Physicians, Internists	Electrocardiographic Diagnosis
May		
5-6	Ophthalmologists	Ophthalmology Conference: Cornea & External Disease
12	Dermatologists, Family Physicians	Common Dermatologic Problems
16-20	Internists	Advances in Internal Medicine
26	Pathologists	Continuing Pathology Conference
June		
2-3	Medical Technologists	Blood Banking
7	Pathologists	Continuing Pathology Conference
8-10	Family Physicians Internists	Pulmonary Disease Workshop
20-24	Family Physicians, Internists, Pediatricians	*Northern Michigan Summer Conference

Complete information is available from the Department of Postgraduate Medicine, Towsley Center for Continuing Medical Education, Ann Arbor 48109.

*This conference will be held at Shanty Creek Lodge, Bellaire, Mich.

Gastrointestinal Workshop at Lexington

The University of Kentucky Medical Center has scheduled a Gastrointestinal Workshop for the Practicing Physician on Dec. 17-18 at Lexington. Registration fee is $80. For further information, contact Frank R. Lemon, M.D., CME, College of Medicine, Lexington 40506.

Plan Psychopharmacology Symposium

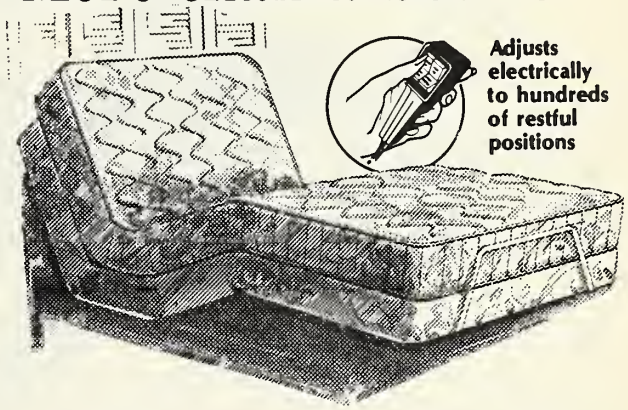
Members of ISMA are invited to attend and participate in the Third International Symposium on Psychopharmacology which will meet at the University of Louisville School of Medicine on Feb. 11 and 12, 1977. Further information may be obtained by writing to Dr. Herman C. B. Denver, professor of psychiatry, Health Sciences Center, Louisville 40201.

Emergency Medicine Seminar Planned

The Indiana chapters of the American College of Emergency Physicians and the Emergency Department Nurses Association will present a seminar at the Airport Hilton Inn, Indianapolis, May 11 through 14, 1977. The Indiana University School of Medicine is a co-sponsor.

Fees are $50-$100. Information: David Gettle, M.D., 10005 Hillsdale, Carmel, IN 46032; 317-844-7105.

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There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

Long Finger

I think it's best to call the middle digit of each hand, the "long finger."

It certainly is descriptive and short—one syllable—to call this middle digit, "long." I remember one of my children proudly reciting what she had learned in kindergarten that day; it was: "thumb man, pointer, tall man, ring man, and pinkie." It was delightful to hear her childish recital of the names of the digits of the hand this way. But as time passed, and I thought of it, it seems increasingly accurate.

Many physicians think of a thumb and four fingers, because they recognize the importance of the opposable thumb, and how this ability to oppose sets the thumb apart from the other digits of the hand—the fingers. Some physicians just speak of five fingers on each hand, as our patients do.

But many physicians who speak of a thumb and four fingers will name the middle digit of the hand, the "middle finger"—as our patients do. This term "middle finger" implies that this middle digit is in the middle of an equal number of fingers on each side.

Those of us who think that there is only one finger and a thumb on one side of this middle digit should not use the term "middle finger," to my thinking. Use of the term "middle finger" implies that the thumb is a finger.

A good alternative is "long finger." I can't claim authorship for this term; it's been in use by hand surgeons and orthopedic surgeons for some time.

Because "long finger" doesn't imply that the thumb is a finger, as use of the term "middle finger" does, and because it is a more descriptive term and a shorter term, I suggest that we use "long finger" as the clinical name for this digit.

3901 Lincoln
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The theme for the 5th annual AMA National Leadership Conference, Jan. 20-23, at the O'Hare Marriott Motor Hotel, Chicago, will be "Portrait: Dynamic Leadership for '77." Special interest sessions slated for the program include "Cost of Care," "Quality of Care" and "Toward a National Health System—A Global Perspective." A seminar titled "Assault on Professionalism" will be the forum for a discussion of current and widespread attacks on the various professions. Seven optional seminars on topics not planned for the regular meeting will be offered on Jan. 20.



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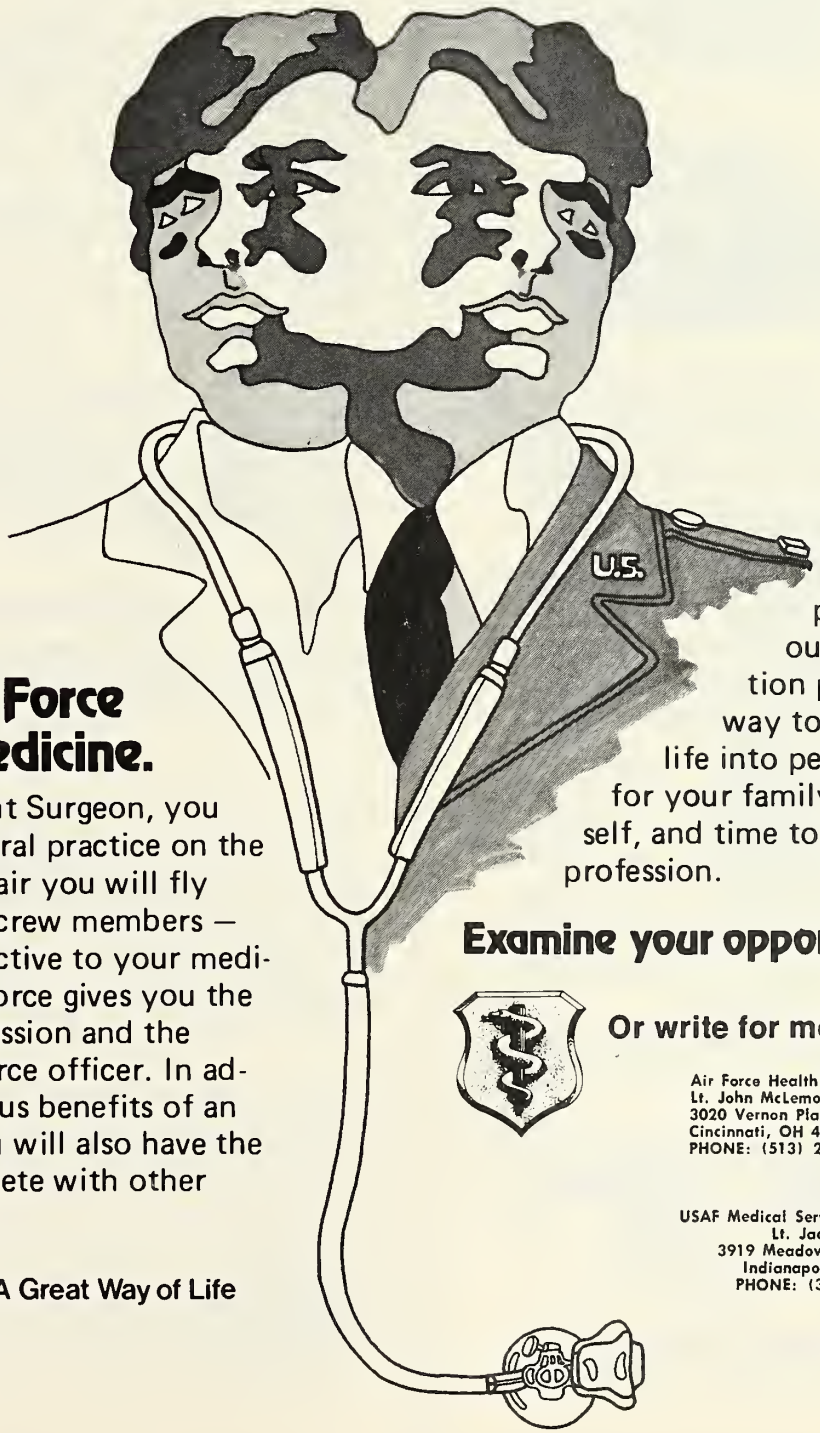
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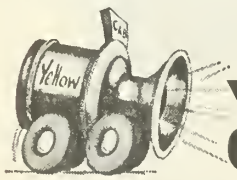
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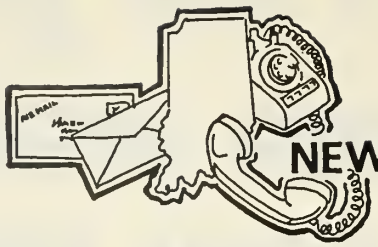
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NEWS NOTES

Echocardiography Program Oversubscribed

Dr. Harvey Feigenbaum, Indianapolis, senior research associate at the Krannert Institute for Cardiology, is acknowledged as an international authority on the use of high frequency sound (echocardiography) in diagnosis of heart disease. He and his associates presented a short course in "Advanced Echocardiography" in Indianapolis in September. The course, limited to 300, was oversubscribed.

IDAA Chapter Formed at Cincinnati

The International Doctors in Alcoholics Anonymous (IDAA) announces a new chapter in Cincinnati. For full information call (513) 683-8025.

VA Employs More Handicapped Workers

The Veterans Administration is dedicated to increased employment of the handicapped. VA Administrator Richard Roudebush reports that in 1975 the VA employed 12,194 handicapped persons, an increase of 662 over 1974. The handicapped now form 5.6% of the VA's total work force. Roudebush says that handicapped persons make better workers than other people.

Dr. Kuntz Attains Emeritus Rank

Dr. Herman W. Kuntz, Indianapolis, has been awarded the title of assistant professor emeritus of otolaryngology, School of Medicine, by the Trustees of Indiana University, transmitted by a letter of appreciation from President John Ryan.

Alcohol Health, Research Bulletin

"Alcohol Health and Research World," which has been distributed free of cost as an experimental periodical, will be priced in the future at $6.40 per year. It is a quarterly bulletin to inform alcohol-related professionals the fundamentals and changes in the study of alcoholism, treatment, rehabilitation, prevention and research. To subscribe, send remittance to Assistant Public Printer, Superintendent of Documents, Government Printing Office, Washington, D.C. 20402.

Nutrition/Health Center Opens

The Nutrition/Health Information Center has been opened at 666 Fifth Avenue, New York City, to provide, on request, up-to-date, scientifically accurate information, focused initially on obesity, cardiovascular disease, cancer, diabetes, liver and gallbladder function and similar medical problems. Special emphasis will be devoted to the relationship of lipids to each area. The Center is supported by a grant from the Mazola family of products. Written rquests for information will be honored immediately. There is no charge for any of the Center's services.

Ground-breaking Ceremonies Held

Dr. Robert C. Peacock, Muncie, chairman of the executive committee of the Ball Memorial Hospital clinical staff, was one of the speakers at the ground-breaking ceremonies for the hospital's $25 million expansion program on Oct. 1. Others participating in the actual ground-breaking were **Drs. Warren L. Bergwall, Lawrence J. Lawson, John C. Moore** and **Donald R. Taylor,** members of the building committee.

Named Chief of Laboratories

Dr. Harley Palmer, Franklin, has accepted the post of chief of laboratories at Community Hospital, Indianapolis, as of Oct. 1 and has resigned his position as coroner of Johnson County.

Presides over Christian Church Meeting

Dr. Paul Siebenmorgen, Terre Haute family practitioner, presided over the 135th assembly of the Christian Church (Disciples of Christ) held at Indianapolis recently. He has served as moderator for the past year.

Two Appointed Medical Directors

Drs. Dan L. McCaslin and Philip J. Fahey, Fort Wayne, have been promoted to medical directors of the Lincoln National Life Insurance Company.

Take Part in Death, Dying Seminar

Six Jackson County physicians participated in a recent series of seminars on death and dying. On the panel were **Drs. Garland R. Gillespie and Joel L. McGill, Brownstown,** and **Drs. Ian Templeton, Mark Bevers, Ralph Bosch and John Linson, Seymour.**

Hospital Honors Dr. Frank Teague

Dr. Frank Teague, Indianapolis area orthopedic surgeon since 1932, was honored at the annual Chrysanthemum Ball, a fund-raising event for St. Francis Hospital, Beech Grove.

Lutheran Staff Officers Change

Dr. Don E. Miller has assumed the duties of president of the Lutheran Hospital, Fort Wayne, Medical Staff for 1976-77. He succeeds **Dr. Alan D. Richards.**

Dr. B. Trent Cooper was named president-elect. Other officers are **Drs. Dan L. Tritch,** secretary, and **James G. Buchholz,** treasurer.

Executive committee members are **Dr. Richards** (chairman), **Robert Ball, William Hall, Dean Dauscher, Cooper and Miller.**

Dr. Carter Serves as Parade Marshal

Tipton County's oldest practicing physician, **Dr. Jean Val Carter,** served as parade marshal during the recent Tipton County Pork Festival. Riding with him as honorary parade marshal was **Governor Otis M. Bowen, M.D.**

Dr. Robinson on Epilepsy Panel

Dr. Frederick C. Robinson, Lafayette neurologist, participated in a panel discussion on epilepsy at Williamsport recently. This was part of a Community Awareness Program on epilepsy. Also featured was a film from the Epilepsy Foundation of Indiana titled "Images of Epilepsy."



HEARTY GREETINGS were extended to two distinguished guests at the annual meeting of the 10th District Medical Society—Dr. John Budd of Cleveland, president of the American Medical Association (center), and Notre Dame basketball coach Richard "Digger" Phelps (second from right). Greeting them were (left) Dr. Lowell Steen, Hammond, a trustee of the AMA, Dr. Martin O'Neill, a Trustee of the Indiana State Medical Association, and (right) Dr. Vincent J. Santare, 1975-76 president of the ISMA.

Named to Malpractice Hearing Panel

Drs. A. Alan Fischer and Stephen Olvey of Indianapolis have been asked to serve on the first medical panel to hear malpractice cases, with Mr. James Stewart, legal counsel.

Prosthetic Care for the Medicare Patient



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Dr. Goodman Chosen President-Elect



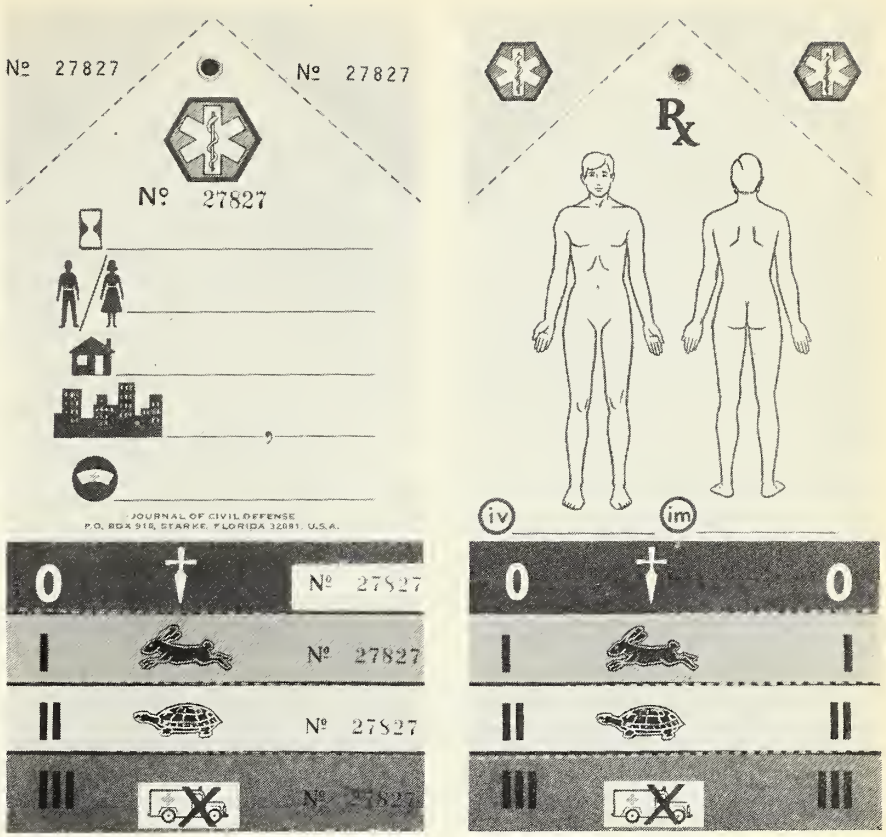
Dr. Eli Goodman, Charlestown general practitioner, was named president-elect of the Indiana State Medical Association at the 127th annual meeting of the association in Indianapolis in October. He will assume the presidency at the group's 1977 convention. Dr. Goodman has been in practice in Clark County since 1946, following a six-year tour of duty with the Army Medical Corps, three years of which were spent in the Pacific Theater. A graduate of Tufts Medical College in 1938, Dr. Goodman served as intern and resident at Woodlawn Hospital, Chicago. For the past year he has been chairman of the ISMA Board of Trustees, having served as a trustee for six years. He is a past president and secretary of both the Clark County and Third District medical societies and has served on and been chairman of a number of committees and commissions. In addition, he has served as a delegate from Clark County for 15 years. The local Red Cross and Community Chest have elected him to office, and he has served as chairman of his Area Comprehensive Health Planning Council and of the Charlestown Civil Defense unit.

Dr. Goodman and his wife reside in Charlestown.

Continuing Medical Education

Announcement has been made that the following Indiana physicians have earned the AMA Physician's Recognition Award recently:

Donald Ray Allen, Evansville
Thomas W. Alley, Indianapolis
Pastor D. Aluning, Rochester
David Lee Alvis, Indianapolis
Milton H. Anderson, Evansville
Herbert Arbeiter, Munster
Joseph S. Bean, Logansport
Mier A. Bizer, Jeffersonville
Clyde G. Botkin, Muncie
Jose S. Cabigas, Richmond
Manuel A. Cacdac, Terre Haute
John A. Cavins, Indianapolis
Jose P. Clemente, Richmond
Patrick W. Connerly, Rushville
Thomas J. Conway, Terre Haute
Patrick J. V. Corcoran, Evansville
Thomas A. Cortese, Indianapolis
H. Sayler Daugherty, Fort Wayne
Francisco Deogracias, Edinburg
Daniel Ching-Yee Dew, Elkhart
August J. Dian, Westville
William H. Dick, Indianapolis
Patrick A. Dolan, Indianapolis
Philip N. Eskew, Jr., Carmel
Otto N. Forrest, South Bend
David R. Gettle, Carmel
Burt R. Goldburg, Marion
David A. Goldsmith, Marion
Oscar Green, Indianapolis
Joseph L. Guckien, Evansville
Elton Heaton, Madison
Eugene Helveston, Indianapolis
Michael A. Herrell, Evansville
Thomas W. Hogan, Terre Haute
Thomas Horwitz, Indianapolis
Richard B. Hovda, Evansville
Tsau-Yuen Huang, Gary
Mohammed Hussain, Jeffersonville
Robert F. Jackson, Marion
Maurice E. John, Jeffersonville
William E. Kelley, Indianapolis
Edwin F. Koch, Muncie
Abdul S. Lalani, LaPorte
Robert H. Larmore, Fort Wayne
Evan L. Lehman, Indianapolis
Patrick C. Logan, Indianapolis
James R. MacKenzie, Indianapolis
Robert M. Malachowski, Indianapolis
Hugh B. McAdams, Lafayette
James Y. McCullough, New Albany
Richard L. McDowell, Fort Wayne
Mark E. Meyers, Evansville
John D. Miller, Indianapolis
Ernest C. Murray, Kokomo
Delbert W. Nelson, Berne
Francis E. O'Brien, Rensselaer
Tjien Oen Oei, Indianapolis
Navin C. Pancholy, Wabash
Jesus F. Pangan, Terre Haute
Camille K. Parker, Logansport
Francis W. Parker, Logansport
Jose Peralta, Crawfordsville
George C. Poolitsan, Bloomington
George B. Pratt, Zionsville
Edward L. Probst, Columbus
Shokri Radpour, Kokomo
Joseph L. Rayes, Princeton
Venkata Reddy, Indianapolis
Paul H. Reitman, East Chicago
Jerry Rothenberg, Evansville
Charles H. Rushmore, Indianapolis
John J. Saalwaechter, Lebanon
David Sabbar, Griffith
Alexander L. Scheer, Elkhart
Theodore F. Schlaegel, Indianapolis
Paul E. Schmidt, Indianapolis
Samuel L. Scott, Indianapolis
Richard L. Shoemaker, Gas City
Wilbur L. Smith, Indianapolis
Irvin H. Sonne, New Albany
Beaufort A. Spencer, Bloomington
Charles H. Spurgeon, Indianapolis
Susan R. Stephens, Carmel
Joseph S. Stratigos, South Bend
James W. Strickland, Indianapolis
John D. Tharp, Muncie
Verapon Towannasut, Merrillville
Willo F. Ungemach, Fort Wayne
Edmund L. VanBuskirk, Lafayette
Lawrence J. Vogel, Mount Vernon
George J. Volan, Merrillville
Arthur L. Wagner, Jasper
William M. Wahle, Indianapolis
Peter Lee Winters, Indianapolis
Harry C. Wolf, Indianapolis
Eusebio C. Young, Indianapolis
William H. Zimmerman, Syracuse



This four-color Medical Emergency Triage Tag (METTAG) has been developed by the Journal of Civil Defense. International symbols for time, sex of patient, address and identification of medical attendant are suited for use by non-English speaking emergency workers. Body outlines are useful to depiction of injury. Triage classification is accomplished by leaving the entire triage tag to indicate that hospitalization is not needed, by removing the ambulance picture to leave the slow turtle for routine evacuation, or the rapid rabbit for urgent transportation, or the international death symbol for the expired victim.

Hoosier Physicians Announce Retirement

The Journal has received word of the retirement of the following physicians:

Dr. Otto F. Lehmberg, Columbia City,
Dr. Alexander W. Cavins, Terre Haute
Dr. Berniece Williams, Fort Wayne
Dr. John R. Baum, Warsaw
Dr. Mary Norris Surratt, Indianapolis

Assists at Clinic on Sioux Reservation

"Alcoholism is probably the greatest problem confronting 1,400 Sioux Indians living on the Fort Totten Reservation near Devil's Lake, N.D.," according to **Dr. Frederick Poehler,** who spent one week this summer on the reservation. The LaFontaine physician, who is also Wabash County Health Officer, his wife and son were part of a Methodist Church "work caravan" which journeyed to the reservation to help the Sioux repair their houses and bodies.

Pamphlet on Understanding Stress

Public Affairs Pamphlet #538 carries the title "Understanding Stress." It discusses what is meant by stress, what damage it can cause and also why we need it. Available at cost of 35 cents. Address is 381 Park Avenue South, New York City 10016.

Certified as Neurological Surgeon

The American Board of Neurological Surgery has announced the certification of **Dr. K. Vijaya Prasanthan Pillay, Crown Point.**

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Deaths

Paul Edward Davis, M.D.

Dr. Paul E. Davis, Terre Haute, died Aug. 15 while on a fishing trip at Great Bear Lake in the Yukon Territory, Canada. He was 44.

A 1961 graduate of the Indiana University School of Medicine, Dr. Davis interned at the Marion County General Hospital and had been in general practice at Terre Haute since completing his internship. He was on the staff of Union Hospital.

During World War II Dr. Davis served with the United States Air Force.

He was a member of the American Medical Association and the Vigo County Medical Society.

Francis E. Donahue, M.D.

Dr. Francis Edward Donahue, Dublin, died Aug. 18 in Indiana University Hospital of burns suffered in a home fire. He was 56.

Dr. Donahue had practiced in Dublin since July 1, 1959, following one year's affiliation with the New Castle Clinic. He was a 1956 graduate of the Indiana University School of Medicine and interned at Indianapolis General Hospital.

During World War II Dr. Donahue served as a navigator in Europe and North Africa, receiving the Air Medal and Distinguished Fying Cross.

He was a member of the Henry County Medical Society and the American Medical Association.

Thomas W. Dunning, M.D.

Dr. Thomas W. Dunning, Muncie, died in a fire at his home Aug. 29 that also resulted in the death of his wife and two children. He was 48.

A 1954 graduate of St. Louis University Medical School, Dr. Dunning interned at Methodist Hospital, Indianapolis, and Queen of Angels Hospital, Los Angeles.

Dr. Dunning had been in general practice at Muncie since 1955. He was a member of the Delaware-Blackford County Medical Society and the American Medical Association.

Wallace K. Dyer, M.D.

Dr. Wallace Knapp Dyer, 63, Evansville otolaryngologist, died Aug. 3 in St. Mary's Hospital. He had been retired for about a year because of ill health.

Dr. Dyer graduated from the Indiana University School of Medicine in 1940 and interned at Indianapolis General Hospital, where he also was a resident in otolaryngology and ophthalmology. He served in the U. S. Army in World War II, his tour of duty taking him to Africa and Italy.

A diplomate of the American Board of Otolaryngology, Dr. Dyer was a member of the Vanderburgh County Medical Society and the American Medical Association.

Lewis E. Jolly, M.D.

Dr. Lewis E. Jolly, former Madison physician, died in his home at Hanover Aug. 23. He was 64.

Dr. Jolly was a graduate of the University of Colorado Medical School and was affiliated with the Veterans Administration Hospital at Dayton, Ohio, before moving to Madison in 1947. He had recently been working in the emergency room at St. Francis Hospital, Beech Grove.

A former member of the Henry County and Jefferson County medical societies, Dr. Jolly was also a former member of the American Medical Association.

Ben L. Leming, M.D.

Dr. Ben L. Leming, 58, who formerly practiced general and thoracic surgery in Fort Wayne, died May 30 at his home in St. Louis, Mo.

A graduate of the Indiana University School of Medicine, Dr. Leming interned at a Buffalo, N.Y., hospital and served as a resident at the Rozwell Park Cancer Research Center.

During World War II he saw service in the U. S. Army.

Dr. Leming was a former member of the Fort Wayne-Allen County Medical Society and was a member of the American College of Surgeons.

Virgil G. McDonald, M.D.

Dr. Virgil Gwinn McDonald, 90, retired Anderson physician, died Aug. 25.

A 1910 graduate of the Indiana University School of Medicine, Dr. McDonald had special training in surgery at Washington University, St. Louis. He retired in 1965 after 55 years in the medical profession.

Dr. McDonald was a member of the American College of Surgeons, the Madison County Medical Society and the American Medical Association. He was a Senior Member of the Indiana State Medical Association and a member of its 50-Year Club.

Edwin J. Nugent, M.D.

Dr. Edwin Joseph Nugent, Indianapolis, died Aug. 10, in St. Vincent Hospital. He was 73.

In 1948 Dr. Nugent moved to Indianapolis, where he served as medical director at Detroit Diesel, Allison Division of General Motors, until his retirement in 1967.

His medical degree was obtained at the University of Rochester School of Medicine, following which he interned at Mt. Sinai Hospital, Hartford, Conn., and Strong Memorial Hospital, Rochester. He was certified by the American Boards of Preventive Medicine and Occupational Medicine.

A member of the Marion County Medical Society, Dr. Nugent became a senior member of the Indiana State Medical Association in 1974. He was also a member of the American Medical Association.

Howard W. Pierson, Jr., M.D.

Dr. Howard Wilson Pierson, Jr., Gary, died May 1, 1976, at Gary. He was 56.

Formcr Health Services Director for the Gary schools, Dr. Pierson had been in the practice of obstetrics at Merrillville since 1966. He was a 1944 graduate of Jefferson Medical College of Philadelphia, interned at Muhlenberg Hospital, Plainfield, N.J., and completed residencies in obstetrics at Cooper Hospital, Camden, N.J., and Bayonne Hospital, Bayonne. During World War II Dr. Pierson served with the U.S. Navy Medical Corps.

Dr. Pierson was in private practice in New Jersey from 1947 until coming to Gary in 1963. While in New Jersey he had also served as a health commissioner.

Dr. Pierson was a member of the Lake County Medical Society and the American Medical Association.

Alfred B. Scales, M.D.

Dr. Alfred B. Scales, 76, Huntingburg, died Aug. 24 in St. Joseph's Hospital, Huntingburg.

During World War I Dr. Scales was in the Student Army Training Corps, during World War II he served with the Army in the Southwest Pacific area for three years, and he was recalled to active duty during the Korean conflict, serving as post surgeon at Fort Benjamin Harrison. During this time he directed the moving of the hospital from Camp At-

terbury to the Fort. Following World War II Dr. Scales set up his practice in Evansville. He also spent four years as a surgeon with the Army Corps of Engineers while they were building a dam on the Missouri River.

In 1954 he moved to Huntingburg, where he maintained an active practice until his retirement in 1974.

Dr. Scales graduated from the Indiana University School of Medicine in 1937; he was a high school teacher and principal for 12 years before enrolling in medical school. He interned and was in a surgical residency at Welborn Baptist Hospital, Evansville. He was certified by the American Board of Abdominal Surgery in 1959.

A member of the American Medical Association, Dr. Scales served twice as president of the Dubois County Medical Society.

William K. Sennett, M.D.

Dr. William Kelsey Sennett, Macy, died Aug. 22 at home. He was 73 and retired from active practice.

A 1933 graduate of the Indiana University School of Medicine, Dr. Sennett interned and served a residency at Indianapolis City Hospital and had been in general practice at Macy for 38 years. He was on the medical staff of Dukes Miami County Hospital and Woodlawn Hospital, Rochester.

He was on active duty with the U.S. Army from January 1941 to Dec. 1945 and saw service in the China-Burma-India Theater as commander of a field hospital and ambulance company.

Dr. Sennett was a member of the Miami County Medical Society and was elected to Senior Membership in the Indiana State Medical Association in 1973.

James S. Smith, M.D.

Dr. James S. Smith, former Muncie physician, died Aug. 5 in Los Angeles, where he had practiced since 1966. He was 73.

Dr. Smith first practiced medicine in Hutchinson, Kan., following his graduation from the Howard University Medical School in 1934. In 1940 he moved to Muncie, where he served as president of the Eighth District of the Indiana Academy of General Practice, the first black physician to serve in that post. He was a charter member and past president of the Hoosier State Medical Society and served as a vice president of the Delaware-Blackford Medical Society.

The solution to physician reimbursement problems under Medicare "will occur only when Congress is willing to adopt a policy of reimbursing for services rendered at a level more nearly reflective of usual and customary charges," AMA Board of Trustees Chairman Raymond T. Holden, M.D., told the House Ways and Means Subcommittee on Health. The real issue, he said, is "promises versus payment by the federal government." Dr. Holden pointed out that charges recognized under Medicare have never led to inflation but instead have followed the inflationary spiral. Physician charges are based on data that is up to two years old, putting physicians in the position of absorbing today's increased costs while being reimbursed on the basis of yesterday's charges.

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From the *Transactions of the Indiana State Medical Society* 100 Years Ago

I suppose, of course, that I will not be understood as denying the existence of a pathological condition causing the manifestations to which I have referred, or as asserting that any such deduction can be made from medical literature. The point I desire to make is this: that the morbid condition upon which depends the endless variety of symptoms usually called hysterical, should be considered under the head of general pathology; and is no more entitled to a place under the head of special pathology than is the increase of temperature which we denominate "fever."

I have already referred to a property common to all nerve tissue—that is, the susceptibility of receiving impressions, and the ability to respond thereto, and called by physiologists, irritability. The abnormal manifestations that depend upon this property must, of course, be common to every neurosis, and in every instance indicate either one of three conditions, viz: increase, decrease, or entire loss of irritability **"Hysteria," F. J. VanVorhis, M.D., Indianapolis, 1876.**

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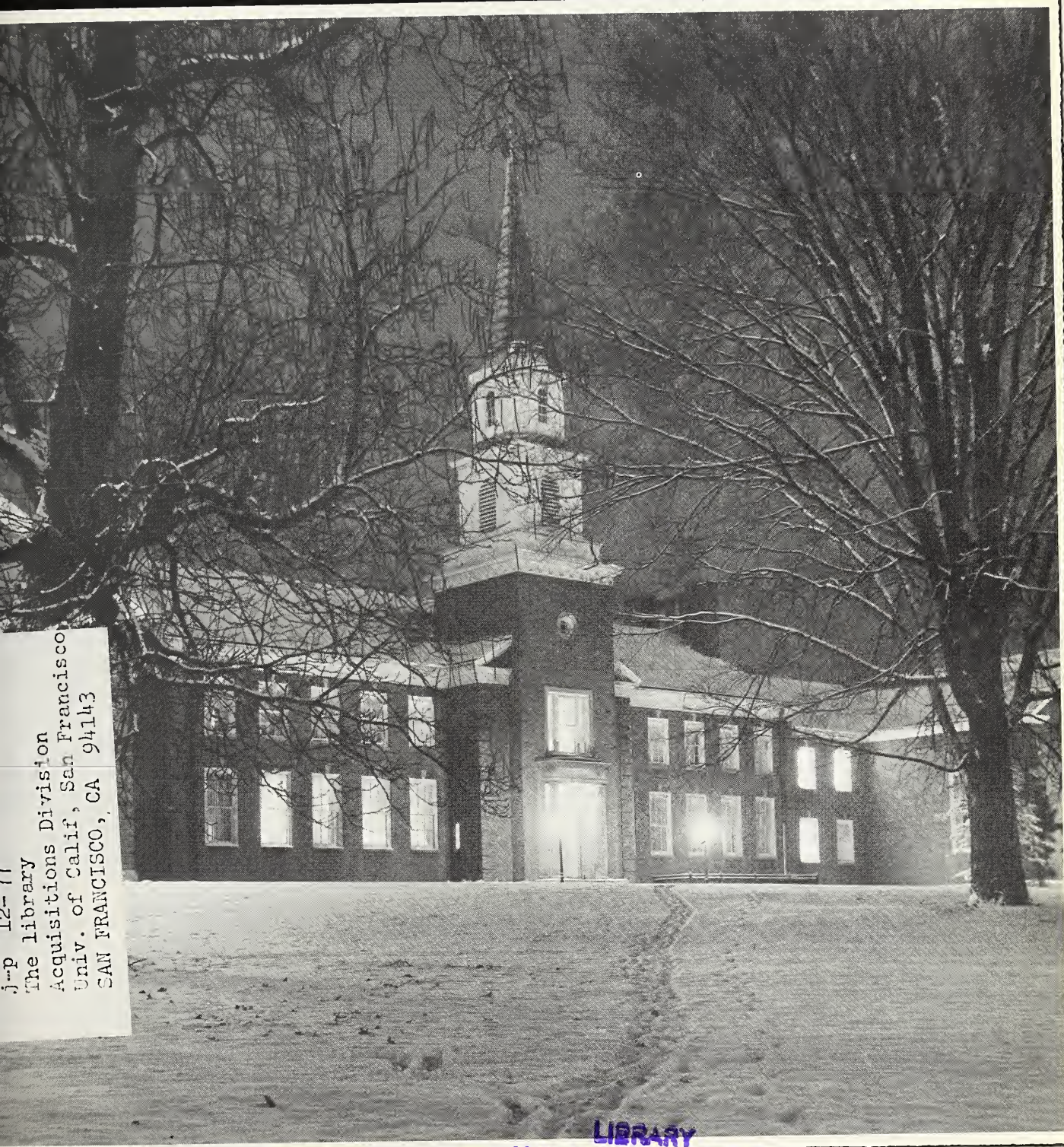
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Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

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MEDICAL MUSEUM NOTES



The Indiana Historical Society sponsors a fall meeting each year wherein the various sections of the Society present individual programs. Last year the Medical History Section, emphasizing the cooperative nature of the museum project, presented the two motion pictures produced by the Educational Resources Department of Indiana University School of Medicine: *The Wisest Man in the Valley* and *Because I Was Too Young,* both documentaries on Indiana's medical history.

This year's program, again stressing the cooperative nature of the project, consisted of a slide presentation illustrating the history of the Old Pathology Building and its development into a medical history museum for Indiana.

The books, instruments, glassware, furniture, photographs and other contributions accessioned during the year were shown in the slide program.

In addition, the program described the advisory and supportive role of the Indiana State Medical Association. (The Medical History Committee of the ISMA serves also a similar function for the Medical History Section of the IHS, and the membership of the ISMA supports the Museum on a voluntary basis through its annual dues.)

Members of the ISMA Medical History Committee attended. The program included in detail the progress that had been achieved with the Museum during the present year.

As readers of this column know, attention to date with the Museum has centered on the amphitheater, where the history of medical education in Indiana is displayed in terms of portraits, paintings, diplomas and photographs. The most recent addition to this display is the Harry Davis painting of the Fort Wayne College of Medicine. This painting was reproduced in color on the cover of the most recent issue of the *Indiana Medical History Quarterly.*

Two recent accessions are the diploma of Dr. Goethe Link from the Central College of Physicians and Surgeons and his internship diploma from City Hospital in Indianapolis. These two documents together contain the signatures of all the medical educators in Indianapolis at the turn of the century. The diploma from the Central College of Physicians and Surgeons will hang beneath the Davis painting of that school. The City Hospital diploma will be displayed with other memorabilia of this venerable teaching hospital. However, the planning for this exhibit is yet to be done.

A landscaping plan for the grounds was obtained in 1975 from the firm of Browning Day Pollak Associates, Inc. This landscaping aspect of the Museum project is provided by the Indiana State Medical Association Auxiliary and will be touched upon in a future column.

Programs were also presented by other groups: The Indiana Religious History Association, the Genealogy Section, the Archeology Section and the Military History Section. Also, there were Indiana history lectures and a program by the Society of Indiana Pioneers.

ISMA members who have an active interest in the state's history (especially its medical history) are urged to join the Indiana Historical Society. Programs and publications, in addition to those described above, are included with the membership. The address is: The Indiana Historical Society, State Library and Historical Building, Indianapolis 46204. The cost is $15.00 per year.

CHARLES A. BONSETT, M.D.
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PAINTING of the Fort Wayne College of Medicine recently done for the Museum by Harry Davis hangs in the amphitheater.

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* **WRITE FOR REPRINT:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and Female Climacteric. *Drug Therapy*, Sept. 1976.

Is there a true aphrodisiac? How effective are androgens in the management of the male climacteric and male impotence? Article discusses the psychophysiological and hormonal changes in the elderly male and female and therapeutic considerations. The effectiveness of methyltestosterone in the management of male impotence was confirmed by a cross-over, double-blind study using a placebo and Android-25 (methyltestosterone 25 mg.), on 20 males, 50 years of age or older who complained of secondary impotence. Patients received a series of placebo then Android-25, or Android-25 then placebo as follows: 1 tablet/30 days; 2 tablets/30 days; 3 tablets/30 days. Sexual response was evaluated: 0 = no change; + = 25% improvement; ++ = 50% improvement; +++ = 75% improvement. Placebo effectiveness was + or ++ in 12.7% of trials. Android-25 elicited a +, ++ or +++ response in 47.2% of trials. There was often a dose related response not observed with the placebo. This effect was not observed in younger patients (age 28-45 years).

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE: Robert B. Greenblatt, M.D.,** and **D. H. Perez, M.D.:** "The Menopausal Syndrome," *Problems of Libido in the Elderly*, pp. 95-101. Medcom Press, N.Y., 1974. **HOW SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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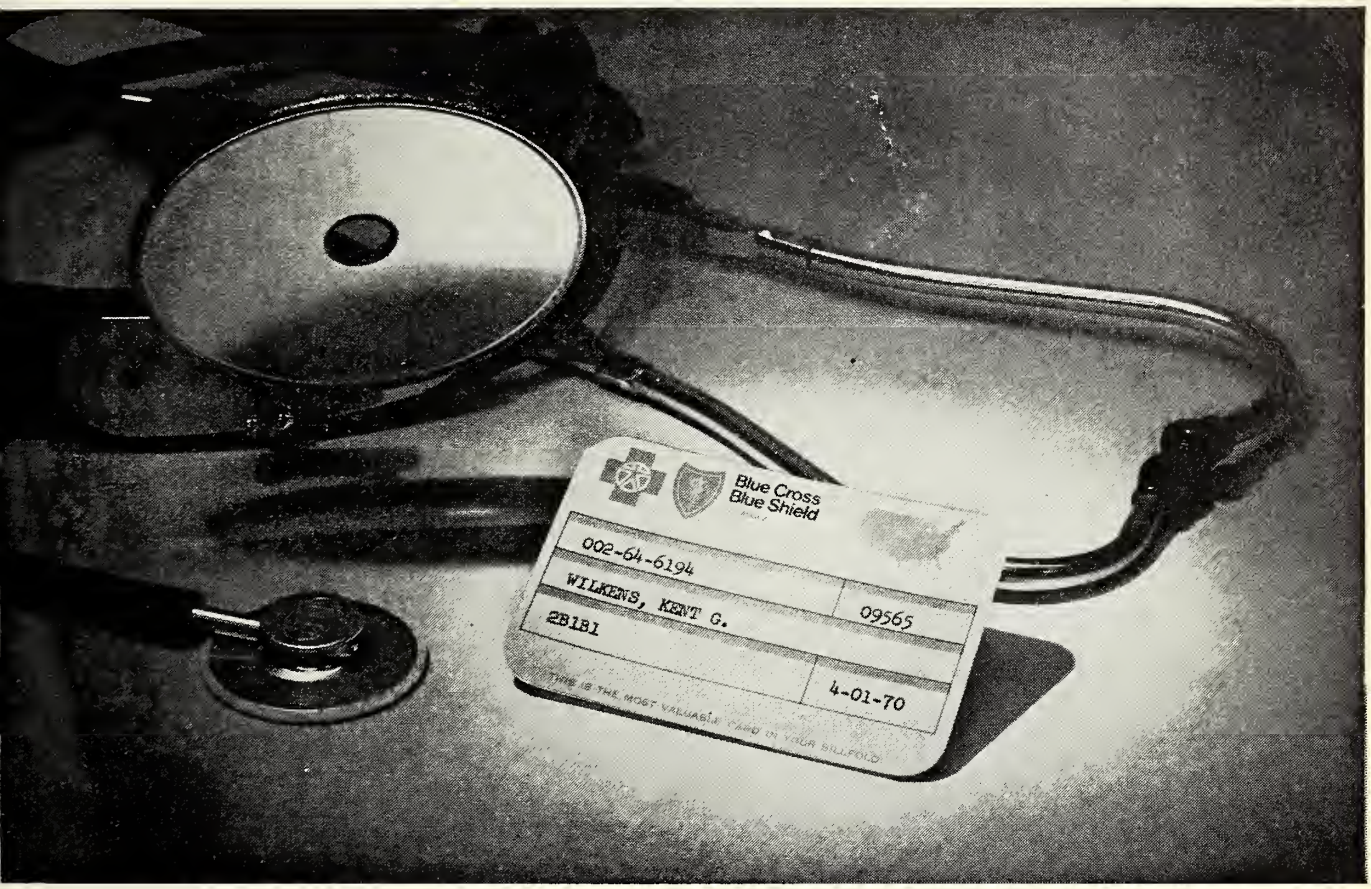
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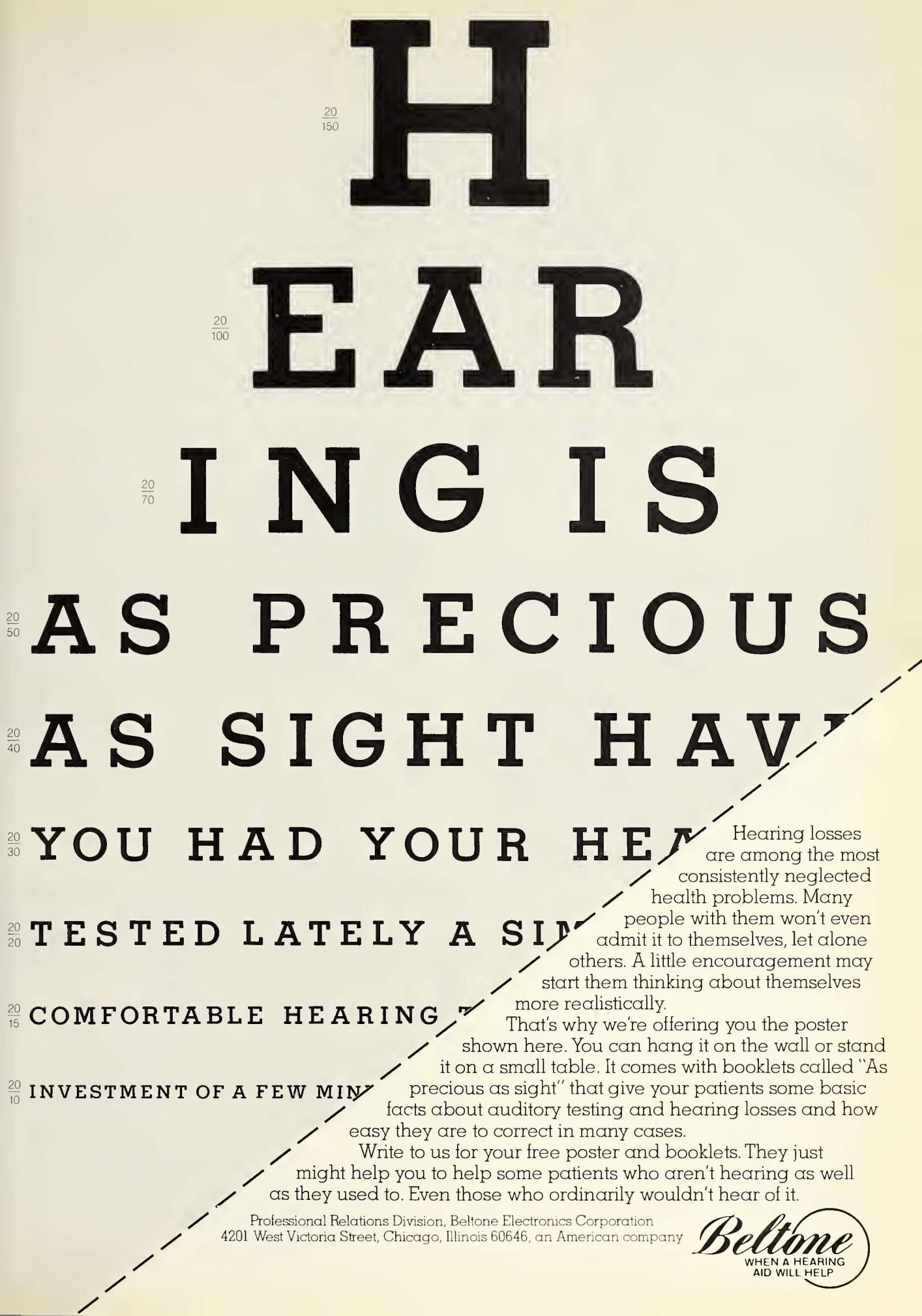
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WHEN A HEARING AID WILL HELP

MONTH IN WASHINGTON

This summary of what is happening in Washington is prepared by AMA's Capitol office and airmailed to The Journal on the first of each month preceding month of issue.

THE POST-WATERGATE 94TH CONGRESS, on paper the most liberal Congress in recent history, refused to adopt any major new federal ventures into the health field.

Nor did the lawmakers vote to impose added controls on providers in an effort to get a handle on soaring costs.

Two important bills bit the dust. One, the Clinical Laboratory Improvement Act, would have set up strict federal standards and licensing for clinical laboratories. The other, the Medicaid Fraud and Abuse Bill, would have strengthened the Health, Education, and Welfare Department's policing of Medicaid abuse and increased penalties for violations. Both of these bills cleared Senate and House committees, but backers were unable to salvage them in the torrent of last-minute action on legislation.

Squeaking through during the final days were bills to set up an Inspector General at HEW to oversee fraud and abuse, especially in medical programs, to continue federal assistance to help states and localities establish emergency medical systems, and to broaden federal aid for Indian health.

Casualties included bills to impose stricter clean air standards, to revise the lobbying laws to require additional reporting, and to change the way the government issues regulations to carry out laws.

THE THREE-YEAR, $2 BILLION aid-for-medical education bill has been signed into law by President Ford who said it "virtually assures that no individual will be denied a medical education for financial reasons."

The Health Professions Education Assistance Act creates a new Health Professions Student Loan Guarantee Program and a Loan Insurance Fund through fiscal 1978.

It continues and expands current medical scholarship programs. In return, recipients will be required to serve in a health manpower shortage area for at least two years.

The compromise legislation strengthens the National Health Service Corps. Before passage, the measure was stripped of many federal control provisions fought by the American Medical Association.

TOTAL SPENDING ON HEALTH CARE in this country is estimated to jump from the current $140 billion to $223.5 billion in five years, according to an actuarial study prepared for HEW.

The study, which figures to be often-cited during next year's Congressional consideration of National Health Insurance (NHI) proposals, also predicts that any NHI plan will add at least $10 billion to the overall expenditures on health. The "induced" spending would come from "encouraging more use of health services covered by the plan, adding administrative expenses for the extra insurance and paying for bad debts and charity services," among other factors, the report said.

THE GOVERNMENT'S POWER TO MOVE against quack remedies suffered a setback when the Federal Appeals Court in Denver recently refused to overturn a District Court decision allowing a cancer patient to buy and transport the questionable anti-cancer product, Laetrile.

The Appeals Court did not rule on the question of whether Laetrile was effective or whether the Food and Drug Administration had the right to bar it from the market. The FDA record on Laetrile was "grossly inadequate," the Court said. "The question whether this is a new drug presents a mixed question of fact and law which should be fully tried," said the Appeals Court. The FDA was ordered to "develop a record supportive of the agency's determination."

The FDA had no immediate comment on the decision. Staff lawyers were unsure how to proceed. However, the Appeals Court muddied the waters on the legal statutes of the controversial drug which has served as a focus for complaints that FDA is overstepping its authority in cracking down on nonauthorized drugs or products.

An Oklahoma City District Court judge had ruled earlier that Laetrile was effective and that the FDA was acting unconstitutionally in seeking to prohibit it.

THE CHARTER CLASS OF 32 at the Uniformed Services University of the Health Sciences was welcomed at ceremonies in Washington, D.C. The five women and 27 men were selected from more than 1,700 applicants.

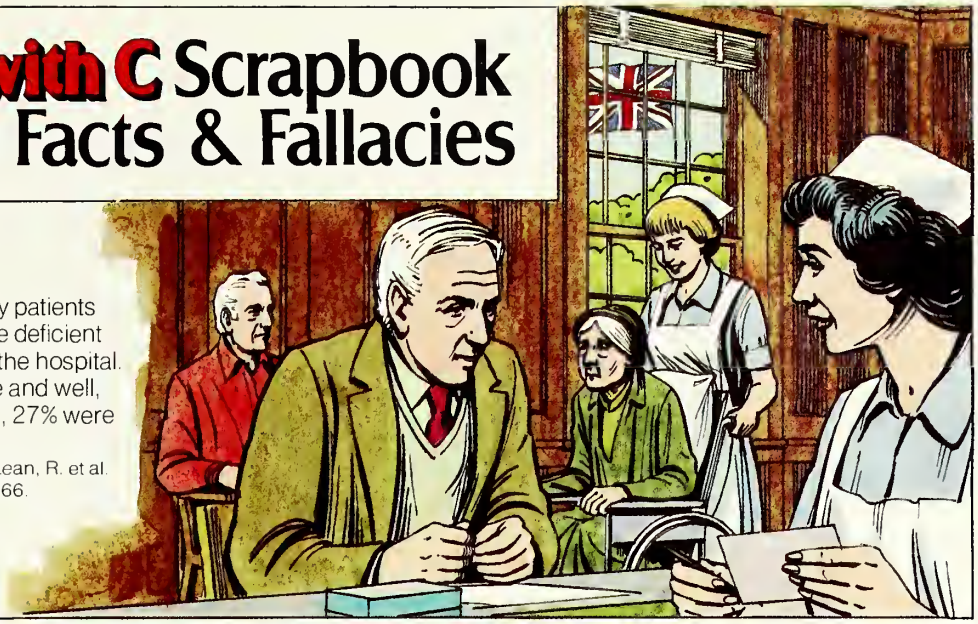
Authorized by Congress in 1972, the school will prepare physicians to practice medicine for the three military services and the Public Health Service. It has received provisional academic accreditation from the Liaison Committee on Medical Education.

The University students are members of Uniformed Services paid at the level of a Second Lieutenant, Ensign, or Junior Assistant Health Officer in the Public Health Service. In return for their education, graduates will incur a minimum obligation of seven years of medical practice in one of the services. ◄



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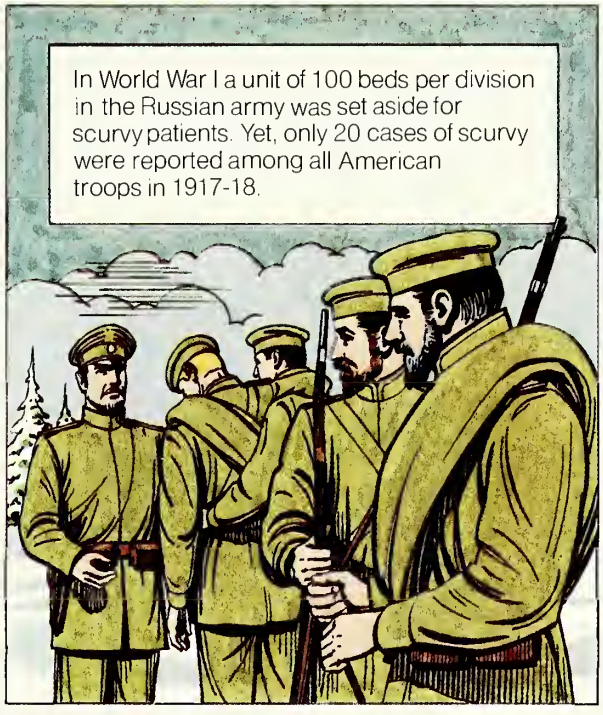


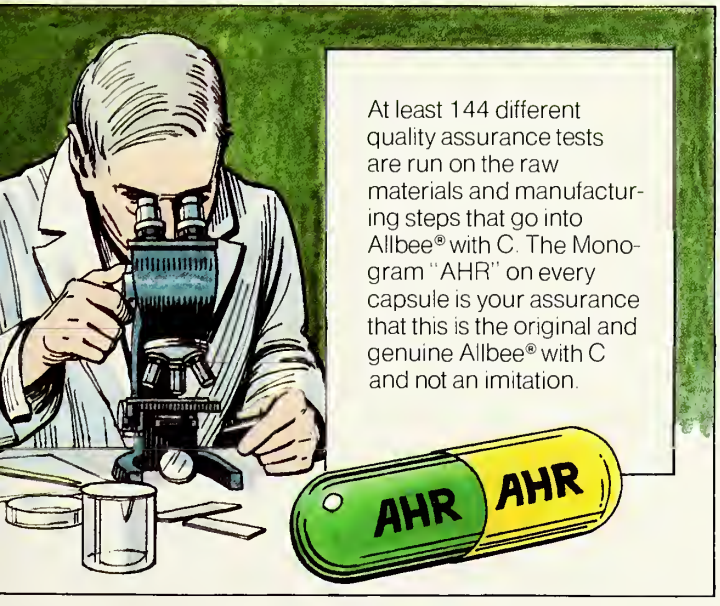
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The Journal of the INDIANA STATE MEDICAL ASSOCIATION

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Increased emphasis has been placed on small intestinal bypass for obesity within the past few years. The authors have presented both the surgical and psychiatric indications for surgery and the proper method of patient evaluation and followup. No serious complications have arisen using this procedure.

Description of the Evaluation Process for Surgically Treated Obesity

DAVID F. WEHLAGE, M.D.
DAVID L. BECHTOLD, M.D.
South Bend

As the knowledge about obesity has gradually increased, there has been an increased emphasis on alternative modalities of treatment and management. The surgical procedure called jejunoileostomy or intestinal bypass was introduced by Kremen and others at the 1954 American Surgical Society meeting[1] after some efforts by Henrickson several years previously to surgically control obesity.[2] Since that time it has gained wide acceptance.[3-14] Because of postoperative metabolic and pyschiatric problems,[15-19] a conservative resistance has prevented abuse of the procedure. Having supported that conservative position, the authors reviewed and explored the standards of preoperative evaluation and selection for intestinal bypass surgery. The purpose of this paper is to describe the essential elements of the evaluation procedures, since we found so much misunderstanding as to how the evaluation has been conducted by others. Some very conservative clinical assumptions which have not been validated were made in excluding some persons, but our mutual clinical experience was helpful in our decisions.

Obesity has been linked with psychiatric evaluation and treatment for decades.[20-22] However, we believe that a definitive surgical and/or medical treatment is more appropriate than psychotherapy.[23-25] We have supported the use of the intestinal bypass procedure but were interested in selecting those patients who could not be helped by any other mode of treatment and could benefit from surgery without postoperative surgical or psychiatric complications. The described preoperative evaluation is required of all patients presenting themselves for surgical amelioration of their obesity.

Surgical Evaluation

The surgical evaluation and examination are completed over a two month period before psychiatric evaluation. If the surgeon feels there is any contraindication for the surgery, he rejects the patient without further evaluation. Patients who would be high surgical risks because of medical problems are not considered eligible for this elective procedure.

The intestinal bypass procedure is designed to create a controlled malabsorption condition which will allow normal body function and still result in reduction of and control of the size of adipose tissue depots. A weight loss of approximately 40% is anticipated with no serious metabolic dysfunction.

Indications for operation are essentially those outlined by Weisman.[13] Obese patients who are considered candidates usually have had a body weight of at least twice ideal weight since puberty with lack of effective response to medical therapy over a three year period. Further indication for operation is the presence of some other serious medical problem for which obesity is a com-

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plicating or causative factor. These primarily include: hypertension, hyperlipidemia, diabetes mellitus, severe lymphatic or venous stasis disorders of the legs, mild coronary artery disease.

If the patient fits the criteria for surgery, further surgical work-up includes: cardiac and pulmonary function studies, x-ray studies of gall bladder, kidneys and entire gastrointestinal tract, thyroid and adrenal function tests, serum triglycerides and glucose tolerance test.

If the surgeon accepts the patient as medically fit, and if he has prepared the patient with full information about bypass surgery, he informs the patient that surgery is conditional pending the psychiatric evaluation. The psychiatrist then either clears the patient completely or conditionally. If the conditional psychiatric acceptance is serious enough to possibly compromise the therapeutic results, the surgeon makes the final decision on whether to operate. In our case, there has always been a mutual agreement on rejecting patients for basically psychiatric reasons. The liaison rapport between the surgeon and the psychiatrist is essential.

Psychiatric Evaluation

If no evidence of hypothyrodism, Cushing's syndrome, or other endocrine disease exists and function tests reveal no evidence of serious medical contraindications to surgery, the patient is scheduled for a psychiatric interview. The psychiatrist explores material in three different areas which include the surgical preparation factors, past history factors, and the obesity factors. It is important that certain questions be posed and explored in each of these areas, in order to gain an estimate of the psychiatric condition of the patient. A physician other than a psychiatrist can properly perform this part of the examination if he understands the nature of the psychiatric information. The following questions are posed to elicit information about the surgical preparation factors:

a. Where did the patient hear about the surgery?
b. What has he heard about it?
c. Does he know what the procedure entails anatomically?
d. Does he know intellectually what the immediate postoperative experiences and complications are?
e. Does he know intellectually what the remote postoperative complications are?
f. What are the therapeutic expectations as the patient understands them?
g. What has he heard about his surgeon?
h. Does he think his surgeon really knows what he is doing?

These questions enable the psychiatrist to check on the adequacy of the surgeon's preparatory communications. We expect the patient to fully understand the immediate and remote scope of the procedure. The psychiatrist looks to discover and correct any anatomical distortions about what is going to be done in the abdomen and any mutilation wishes that may lead to immediate postoperative emotional uncertainties and remote postoperative disenchantment, to which both authors have been extremely sensitive. We insist on the preoperative patient talking to a previously operated patient. We are interested in how expectant the patient is for a magical solution to his obesity and its attendant problems as opposed to the realistic picture we present. How impulsive he has been in seeking the surgery is also important to us. For best results, we expect some hesitant reflection from our patients. We explore the attitudes of close family members to be sure the patient has some support in his efforts. Anyone who whises to proceed against the wishes of close family members, especially the spouse, is generally refused surgery. Trust in the competence of the surgeon is essential for the patient during the painful postoperative realities so as not to create excessive fear that he is not being taken care of properly. Excessive fear of the unknown and lack of confidence in the surgeon combine to precipitate exaggerated emotional difficulties which complicate the clinical progress.

The past history factors we think are important are elicited by exploring the following questions:

a. Has the patient ever had any psychiatric problem after previous surgery?
b. Were there any psychiatric problems in the past for the patient or his family?
c. What is the nature of his emotional background and coping mechanisms?
d. Any alcohol history? Any form of addiction besides food?
e. How has he coped with somatic problems in the past?

With the information from these questions the psychiatrist seeks to predict and prevent any immediate postoperative problems with a recurrent postoperative psychosis or alcohol withdrawal syndrome. We expect relative postoperative abstinence from alcohol, and we do not wish to aggravate the potential hepatic complications of the surgery. Therefore, an alcoholic history makes us very hesitant to operate. Using the psychiatric evaluation to ferret out any severe mental illness like psychosis, the psychiatrist can get some predictive idea of whether the patient is too impulsive to cooperate or whether he will be able to cope with the somatic side effects of the surgery. Psychosis masked by the obesity problem, extreme impulsivity, and excessive hypochondriasis will negatively influence our willingness to proceed with surgery or lead to the recommendation of psychotherapy before surgery. Patients generally are not faithful in maintaining their psychiatric involvement after they have had the surgery. We, therefore, test our patients' motivations by requiring psychiatric treatment before surgery, when indicated.

The obesity factors are explored in the following areas:

a. Length of time obesity has been a problem?

b. Social meaning of obesity in family? Anyone else obese?
c. Coping mechanisms used to hide obesity from himself (self-image) and others (self-consciousness and sociability)?
d. What were the rewards of being obese in his family and peer group?
e. What have been his methods of weight control?
f. Does he admit that eating too much makes him fat?
g. How does he control his impulses in other areas (anger, sex)?
h. When is eating worst for him?
i. What are the anticipated advantages of being thin?
j. How capable is he of adapting to a new social and personal image?

The psychiatrist is interested in the extent of body image problems,[26-30] i.e., the patient's feelings about his body and how negative and rejecting he feels about his body. If the patient has some preoperative assertiveness to get ahead and be liked, as well as having a feeling that parts of his body are acceptable (e.g., attractive face, pretty hair), we know that he has a better postoperative prognosis. A patient who has progressed and succeeded vocationally in spite of his obesity is a good candidate. We look for aggressiveness in socializing and feeling acceptable in spite of obesity. The more evidence there is of controlling his impulses in areas other than eating and having achieved some disciplined routine in his life, the more comfortable we feel for a long range success.

The interpersonal use of the obesity is sought from the questions. If the patient has used obesity to make himself unique or special, if he has used it to justify social isolation, and if he has used it to excuse his irresponsibility, a major emotional readaptation for the patient will be necessary. This is discussed openly with the patient; and if the psychiatrist feels the patient does not possess the assets of emotional flexibility to cope with the postoperative changes, then surgery is refused for psychiatric reasons. Some estimate of what the patient thinks thinness will allow him to do that obesity did not is important to disclose unrealistic expectations. We know the patient will benefit from the bypass surgery without psychiatric complications if he has separated from home, had periods of weight loss, engaged in physical exercise and been interested in how he looks in clothes.

We are hesitant in our acceptance for surgery if there is a positive history of extreme passivity and dependence. By taking a history of the patient's understanding about his obesity and his methods of eating, we attempt to assist him in rearranging his eating habits and food temptations for the postoperative period.[32] His cooperation in recognizing he still has an obesity problem which can be controlled beyond the results of the bypass surgery make for a more complete and satisfying result.

Clinical Experience

After all criteria have been met and the patient is accepted for surgery, a jejunoileal bypass operation using the end-to-end technic of Scott is employed.[9-11] Normally, 20 inches of small bowel (12 and 8) is left in continuity. Pre and postoperative care is directed towards prevention of more common lung and wound complications. Patients are also placed on supplementary vitamins, calcium and potassium to avoid potential abnormalities. They are followed closely postoperatively with electrolyte and liver function evaluations. Liver biopsy is done at the time of surgery but not postoperatively unless the BSP exceeds twice normal.

Postoperatively, the surgeon sees the patient for followup every two weeks after discharge from the hospital for two months, then every three months. The psychiatrist sees the patient routinely at approximately three month intervals for one year and more frequently if any emotional problems arise.

Thirty patients have presented to the surgeon for bypass surgery, but the authors have totally evaluated 24 patients and accepted 21 for surgery. The others were rejected by the surgeon for medical reasons without psychiatric evaluation. Of the 21 accepted patients, 18 have been women in their late 20s and early 30s and 3 were men. There have been no major surgical, medical or psychiatric complications in any of our patients.

Minor surgical complications have consisted of one wound infection and one episode of atelectasis. Postoperatively, diarrhea has not been a factor after three weeks. Liver tests have been only slightly abnormal (highest indocyanine green in one patient was 8.5% after one year). Weight loss has been adequate with a mean of 20% at six months and 35% at one year. The minor emotional problems have included frustration about the continued presence of "thinking fat," which resolved over a six month period. One male patient had some minor marital problems resulting from his wife's apprehension about his new social popularity, especially with other women.

It is impossible to validate whether we are too strict in our acceptance criteria, but we believe we have succeeded in eliminating serious, unwarranted surgical and psychiatric complications and would suggest that if this evaluation is followed, complications and compromised results can be prevented.

634 N. Lafayette Blvd.
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THE SCALPEL AND THE PEN

IV. Luke, The Physician

RODNEY A. MANNION, M.D.
LaPorte

PAUL wrote in his letter to the Collosians "Greetings from my beloved Luke, the physician. . . ." Apparently Luke accompanied Paul on his evangelistic wanderings throughout Asia Minor and the Mediterranean world, because Paul again mentions him in letters to Timothy and Philemon.

These are the only three direct references to Luke in the New Testament and yet tradition says he was a Greek physician, born in Antioch, adopted son of a wealthy Roman, highly educated author of the third gospel and the "Acts of the Apostles" and, by his pen, esteemed as a father of the Christian Church.

What of this man of letters, and of medicine, this follower of Jesus of Nazareth who had never known Him in life, this writer who penned, as Renan claimed, "the most beautiful book in the world"? These questions may be answered in part from examination of the New Testament as it has descended through the centuries from the Greek manuscripts wherein the author's character and personality can be surmised by the nuances contained in his writing. The origins of these traditions come also from historical sources stemming from the second century after Christ.

The New Testament is composed essentially of four synoptic accounts of the life of Jesus (Matthew, Mark, Luke and John), the Acts of the Apostles, attributed also to Luke, and the epistles or letters to various Christians and Christian communities written principally by Paul. The third gospel and the "Acts" are addressed to a certain "Theophilus," who is presumed to be a high ranking Roman and, at that time, a recent convert to Christianity. The name is probably a pseudonym and means literally "lover of God."

There is some evidence that a third book was contemplated but either not written or is not in existence today (*Encyclopedia Americana*). "Luke" and "Acts" are disputatious and are for the further knowledge of "Theophilus." In these books the author traces the history of the new religion to about A.D. 70 and he wishes to prove that it complements and was built upon the Hebrew religion and that the followers of Jesus were not revolutionaries or political agitators.

> *Certum est, quia impossible est.* (It is certain because it is impossible.)—Tertullian (A.D. c 155-255)
>
> Everything must have in it a sharp seasoning of truth.—St. Jerome (A.D. c 342-420)

The Gospel according to St. Luke begins:

> Many have been at pains to set forth the history of what time has brought to fulfilment among us, following the tradition of those first eyewitnesses who gave themselves up to the service of the word. And I too, most noble Theophilus, have resolved to put the story in writing for thee as it befell, having first traced it from its beginning, that thou mayst understand the instruction that thou has already received, in all its certainty.

The quiet, precise scholar writing in clear language who is a firm believer is evident even in this first paragraph.

Biblical commentators emphasize the importance of Luke's contribution. As *Encyclopedia Brittanica* states:

> Since much of the contents of this gospel (as well as nearly all of 'Acts') is not preserved in other writings, this writer is for us the most important historian of the beginning of the Christian movement. His distinctive qualities of mind and style give his work additional interest and attractiveness.

Luke was the only non-Jewish author of the New Testament, and his secular, Roman-citizen intellect is discernible even now to the relatively casual reader. He is prone to say "a certain Pharisee" or "a certain Publican," so that persons unacquainted with the details of

Judean geography or customs can understand the situation. In short, as was Paul the Apostle to the Gentiles, so was Luke the Evangelist.

Thus, if Luke was indeed a physician, then perusal of his writing should give an insight into his medical proclivities. And so it does, as Howard Kelly (of the famous four of Johns Hopkins, along with Welch, Osler and Halsted) pointed out in his article of 1928 entitled, "Luke: The Physician and His Writings." Kelly was completely convinced and his points tend to be polemical but on the whole they support the thesis that Luke was either a doctor or a man well versed in medical matters.

Kelly says: "Of particular interest to us as doctors are those unavoidable traces Luke has naturally left in his writings. . . ." Then he mentions excerpts such as the fact that Luke defines the fever in Peter's wife's mother as "great" and relates her cure by Jesus rebuking the fever in greater detail than does Mark. In a similar way, Luke describes a man "full of leprosy" in relative terms. Perhaps these facts seem more significant when read in the original Greek as Kelly was able to do. Of more apparent value in proving Luke's medical credits today is his use of the words "paralelumenous" for paralytic, "epiblepein" for the act of consulting on a patient, and "hudropikos" for drospy—all of which are medical terms as opposed to layman's synonyms used by the other evangelists.

Luke is more specific when he relates the details of Jesus' miracles of healing, suggesting the scientific mind. The story of the Good Samaritan is used in proof obliquely also, because it is unique to Luke, because the pouring of wine and oil into a wound is Hippocratic advice, and, finally, because the Greek word "hemithane" is a medical word for "half dead" and is also found in Galen and others. Although none of these points are irrefutable, they are suggestive.

Doctors have had their critics, it would seem, even in Biblical times,



for the Markan text says (5:26):

> And now a woman who for twelve years had had an issue of blood, *and had undergone much from many physicians, spending all she had on them, and no better for it, but rather grown worse. . . .*

Luke, the presumed medical advocate, recasts this passage more positively by saying, regarding this same patient with menorrhagia (8:43):

> . . . (She) had an issue of blood, *and had spent all her money on doctors without finding one who could cure her. . . .*

Relatives and patients seem still to find it onerous to pay medical fees, especially in less than successful cases.

It should be noted that no historical sources which date prior to the ninth century disagree with Luke's physicianship, so the early fathers of the Church took Paul at his word when he mentions the "dear physician." Incidentally, the first crediting of Luke as the author of the works now attributed to him was by Irenaeus writing about A.D. 185. Eusebius states that he was a Greek from Antioch, while Julius Africanus (born A.D. 165) believed Luke to be tall, a Grecian and that he remained unmarried. There is a tradition also that he died of natural causes at age 74 in Bithynia, which borders on what is now called the Black Sea. Another tradition is that he was martyred and his remains were interred in Constantinople in the fourth century.

For the purposes of this discussion, however, even the exegetes who comment on Luke are struck by the authors' humanity and universality of outlook. He was obviously a man of culture and discernment, much different, indeed, from the unschooled Nazareans of Palestine. He is the most admired of the New Testament writers for his lucid narrative.

There are three famous prayers which are distinctive and found nowhere else but in "Luke." Best known of these is the "Magnificat," (1:46-55) wherein it states:

And Mary said, my soul magnifies the Lord: my spirit has found joy in God who is my Savior because he has looked graciously upon the lowliness of his handmaid. Behold, from this day forward all generations will call me blest. . . .

Luke is said to have had an advanced idea of the worth of womankind for a man of the first century. Again, a renowned verse is recorded when Zachary spoke in prophecy (1:68-70) and, finally, when Jesus as a youngster spoke the prayer in the temple beginning: "Ruler of all, now dost thou let thy servant go in peace, according to thy word . . ." (2:29-32)

A generation ago Kelly gave an admonition to the medical profession which can also serve us today:

It is evident in this era of our so-called Christian Civilization . . . that this ancient physician, Luke, is actually more read, and read in more languages, than any or all subsequent authors, sacred or professional. It would seem, therefore, that we as his colleagues of a later day and generation, should reckon this great progenitor as . . . our patron saint; we owe it to the dignity and reputation of our profession to study attentively the writings, life and history of this eminent *doctor medicinae* as one who has exercised a more profound influence upon the minds and conduct of men than all the writings of all other physicians who have lived in the last two milleniums.

In words of less hyperbole, it is, perhaps, incumbent upon physicians to recognize some of the fountain-



heads of their knowledge and morality and to continue to pursue the high ends which are defined for them by Western civilization and by the Judeo-Christian ethic. Figuratively speaking, it would be sad if we in medicine, as we enter the last quarter of the 20th century since Christ, suddenly dropped the torch, never to lift it again. There are forces in the world today which hark back to so-called pagan times and which would reduce the value placed on human life. God willing, they will be vanquished.

Osler was well versed in the Bible and, in addition, has said that he renewed his spirit by reading from the "Religio Medici" of Thomas Browne before retiring each night. The works of St. Luke represent a "Religio Medici" also, and an occasional perusal of this early Christian doctor and biographer might tend to invigorate the psyche of the modern physician.

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LaPorte 46350

57,236 medical students, a total that includes 15,349 first-year students, were enrolled in the nation's 116 medical schools this fall, according to a survey conducted jointly by the AMA and the Association of American Medical Colleges. The total enrollment—a record number—represents a 29% increase from five years ago and is about 9.7% greater than last year's total. First-year enrollments this fall were 24% greater than the figure of five years ago and about 9.4% greater than last year. Women and minority student enrollments are about the same as last year. Women students represented 20.4% of total enrollment this year, while minority students made up 8.2% of total enrollment and 9.3% of the freshmen class.—AMA Medical and Health News.

Reminder

The biennial registration fee for reregistration for medical physicians was due July 1, 1976, and expiration date for payment was Aug. 31, 1976. The fee is $20 for both in and out-of-state licenses.

Make sure the Board has your correct address.

Medical Licensing Board of Indiana



Big Balanced Rock, Chiricahua Mountains, Arizona (approx. 1,000 tons)

Most Widely Prescribed—Antivert is the most widely prescribed agent for the management of vertigo* associated with diseases affecting the vestibular system such as Menière's disease, labyrinthitis, and vestibular neuronitis.

Relief of Nausea and Vomiting—Antivert/25 can relieve the nausea and vomiting often associated with vertigo.*

Dosage for Vertigo* —The usual adult dosage for Antivert/25 is one tablet t.i.d.

BRIEF SUMMARY OF PRESCRIBING INFORMATION

*INDICATIONS. Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

Effective: Management of nausea and vomiting and dizziness associated with motion sickness.

Possibly Effective: Management of vertigo associated with diseases affecting the vestibular system.

Final classification of the less than effective indications requires further investigation.

CONTRAINDICATIONS. Administration of Antivert (meclizine HCl) during pregnancy or to women who may become pregnant is contraindicated in view of the teratogenic effect of the drug in rats.

The administration of meclizine to pregnant rats during the 12-15 day of gestation has produced cleft palate in the offspring. Limited studies using doses of over 100 mg./kg./day in rabbits and 10 mg./kg./day in pigs and monkeys did not show cleft palate. Congeners of meclizine have caused cleft palate in species other than the rat.

Meclizine HCl is contraindicated in individuals who have shown a previous hypersensitivity to it.

WARNINGS. Since drowsiness may, on occasion, occur with use of this drug, patients should be warned of this possibility and cautioned against driving a car or operating dangerous machinery.

Usage in Children: Clinical studies establishing safety and effectiveness in children have not been done; therefore, usage is not recommended in the pediatric age group.

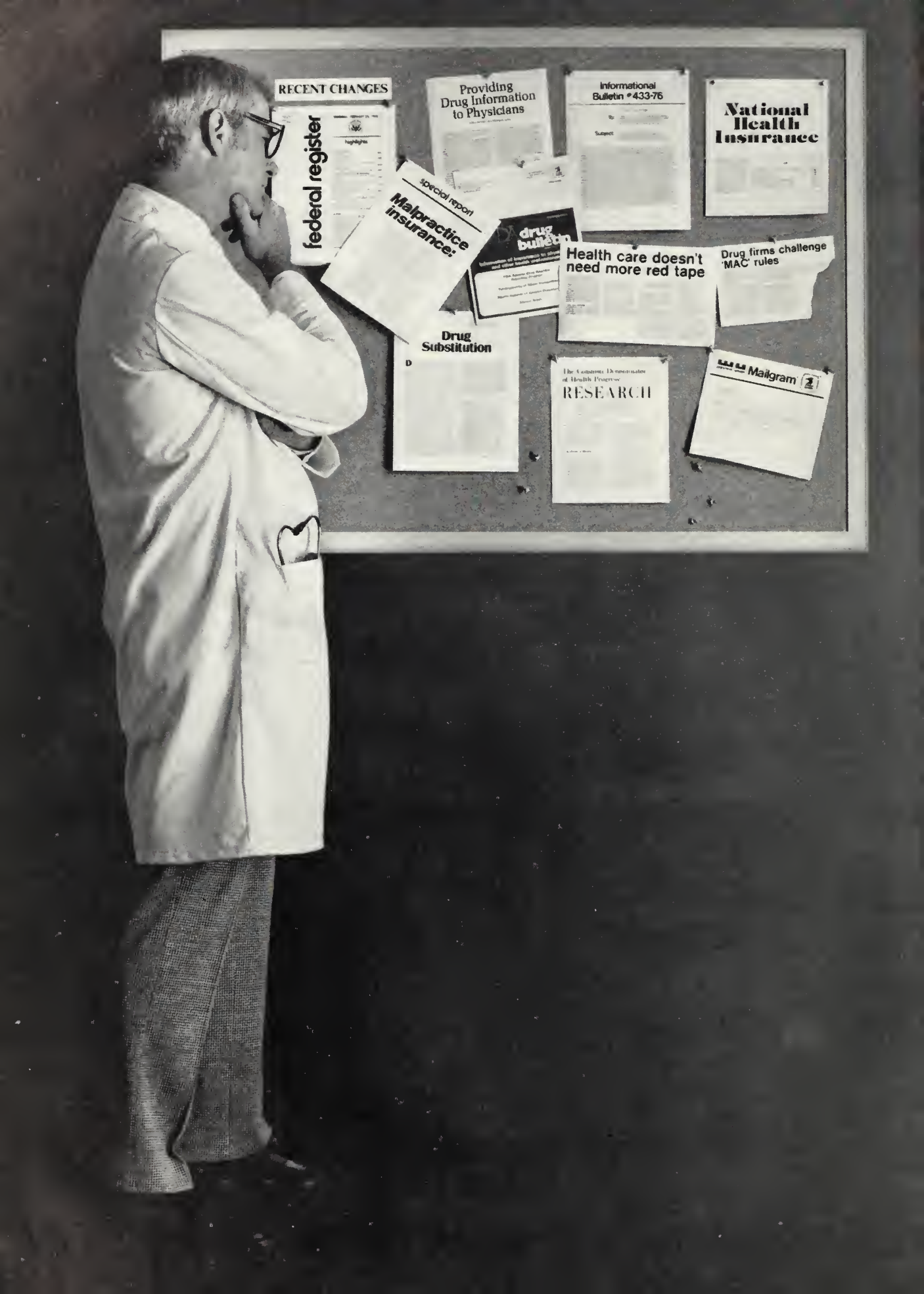
Usage in Pregnancy: See "Contraindications."

ADVERSE REACTIONS. Drowsiness, dry mouth and, on rare occasions, blurred vision have been reported.

More detailed professional information available on request.

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RECENT CHANGES
federal register
Providing Drug Information to Physicians
Informational Bulletin #433-76
National Health Insurance
special report
Malpractice insurance:
drug bulletin
Health care doesn't need more red tape
Drug firms challenge 'MAC' rules
Drug Substitution
RESEARCH
Mailgram

THERE ARE A LOT OF PEOPLE GETTING BETWEEN YOU AND YOUR PATIENT.

Medicine today is in the spotlight, subjected to all kinds of scrutiny. Your control over patient therapy is being monitored, judged and occasionally abrogated, sometimes by unknown third parties.

The worry is that in the wake of this focus, the relationship between you and your patient will be weakened, without offsetting benefits. Consider three examples:

Drug substitution In most states, pharmacy laws, regulations or professional custom stipulate that your non-generic prescriptions be filled with the precise products you prescribe. But in the last five years, a dozen or more State laws have been changed, permitting the pharmacist in most cases to select a product of the same generic drug to fill any prescription.

Ironically, this dilution of physician control has taken place against a background of growing evidence that purportedly equivalent drug products may be inequivalent, since neither present drug standards nor their enforcement are optimal. In fact, the FDA itself says it has not enforced the same standards for hundreds of "follow-on" products that it had applied to the original NDA approvals. Thus physician control over patient therapy is being eroded with a risk that patients may be exposed to drugs of uncertain quality.

The major advertised claim for substitution is reduced prescription prices for consumers. Yet no documentation of any significant savings has been produced.

MAC Maximum Allowable Cost, MAC for short, is a Federal regulation designed to cut the Government's drug bill by setting price ceilings for drugs dispensed to Medicare and Medicaid patients. Unless the prescriber certifies on the prescription that a particular product is medically necessary, the Government intends to pay only for the cost of the lowest-priced, purportedly-equivalent, generally-available product. The effect of the program may be that elderly and indigent patients will be restricted to products which someone in Washington believes are priced right. Practicing doctors will have little to say about administration of the program, since Government will have absolute authority to make its choices stick.

The drug lag The future of drug and device research depends upon a scientific and regulatory environment that encourages therapeutic innovations. The American pharmaceutical industry annually is spending more than $1 billion of its own funds and evaluating more than 1,200 investigational compounds in clinical research. Disease targets include cancer, atherosclerosis, viruses and central nervous system disorders, among others. But there is a major barrier to the flow of new drugs to your patients: The cost of the research is more than ten times what it was, per product, in 1962; and whereas governmental clearance of new drug applications took six months then, it commonly consumes two years now.

The FDA needs adequate time, of course, to consider data. But it is equally clear that the present approval process contributes to needless delay of needed therapy. That's why the increased efficiency of the drug approval process is vital to all our futures.

If these issues concern you, we suggest that you make your voice heard—among your colleagues and your representatives in State legislatures and in Washington.

It could make a difference in your practice tomorrow.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W., Washington, D.C. 20005

A Plea for Diagnosis of the Symptomatic Carotid Atheroma

NORMAN R. HERTZER, M.D.
Cleveland, Ohio

ACTUARIAL statistics consistently place cerebrovascular disease among the leading causes of death in the United States, yet statistics alone cannot reflect the staggering financial and emotional burden imposed by nonfatal but disabling strokes upon patients and families alike. Despite the magnitude of the problem, many patients with symptoms of cerebral ischemia have been treated in the past with a blend of physiotherapy and therapeutic nihilism because of a consensus that the arteriosclerotic lesions responsible for stroke invariably were located within the inaccessible intracranial circulation and represented an inevitable vexation of advancing age. In fact, such is not the case.

Since the advent of precise diagnostic cerebral arteriography and the initial report in 1954 of successful carotid artery reconstruction for cerebral ischemia,[5] it has been clearly established that a striking number of patients with either transient cerebral ischemic attacks or completed strokes have significant arteriosclerosis of the extracranial vasculature amenable to curative operation.[1,6]

Moreover, many patients who eventually develop major neurologic losses experience distinct prodromal transient ischemic attacks which often are accompanied by the presence of audible bruits at the level of the carotid bifurcation, the principal site of extracranial disease in the vast majority of cases. Unfortunately, many physicians not directly involved with the treatment of vascular disorders are unaware of the ominous implications of transient ischemic attacks, overlook routine auscultation of the carotid arteries to detect bruits, and still view carotid endarterectomy and other methods of cerebrovascular repair merely as experimental procedures.

By definition, a transient ischemic attack (TIA) is manifest by a temporary neurologic deficit which occurs suddenly, lasts from a few minutes to several hours, and is followed by full recovery. The attack may consist of peripheral or facial paresthesia or motor loss, aphasia, or monocular visual field blurring or blindness (amaurosis fugax) with lesions of the carotid system.



FIGURE 1

Photograph of an ulcerated arteriosclerotic plaque removed by carotid endarterectomy. Platelet aggregates, fibrin, and atheromatous debris may collect on the granular surface of the lesion and embolize to the brain or retina. Note the smooth transition to normal intima of the internal carotid artery at the upper aspect of the specimen.

Arteriosclerotic stenosis of the carotid bifurcation and proximal internal carotid artery may cause TIA by reduction of total cerebral blood flow below a critical volume, especially in the presence of severe contralateral internal carotid stenosis or occlusion. However, considerable evidence suggests that cerebral or retinal embolization of platelet aggregates, fibrin, or atheromatous debris from ulcerated carotid arteriosclerotic plaques (Fig. 1) is responsible for most symptoms. While eventual occlusion of a stenotic internal carotid artery certainly can create a major stroke, Moore and Hall[7] have made the observation that occlusion not only may occur without neurologic deficit, but may eliminate further TIA by making continued embolization impossible. The importance of platelet emboli is further supported by ophthalmologists who have witnessed the dispersal of glittering platelet aggregates through the retinal arterioles, and by the proven efficiency of heparin and aspirin in controlling the frequency of TIA by virtue of their effects upon platelet adhesiveness.

The presence of a bruit at the level of the carotid bifurcation is very suggestive of significant arteriosclerosis, but obviously will not be detected unless cervical auscultation becomes as permanent a fixture of routine physical examination as auscultation of the precordium.

This article was written while the author was associated with the Department of Surgery, the Arnett Clinic, Lafayette. He is presently associated with the Department of Vascular Surgery, The Cleveland Clinic, 9500 Euclid Ave., Cleveland 44106.

DeWeese and associates[4] found cervical bruits in 84% of a large series of patients with TIA. David and associates[3] correlated bruits with arteriographic findings of over 400 patients with and without cerebral ischemic symptoms. They discovered that bruits were present in 88% of patients with greater than 50% stenosis of the internal carotid artery, and that the intensity of a bruit varies directly with the severity of stenosis. Just as importantly, both investigators encountered a number of symptomatic patients (16% and 14%, respectively) who had no bruits to indicate at the time of physical examination the extent of carotid arteriosclerosis subsequently shown by arteriography.

Studies such as these confirm the importance of routine carotid auscultation, but they emphasize as well the critical fact that arteriography is necessary to prove incontrovertibly that correctable extracranial disease is not responsible for previous stroke or typical TIA. The importance of a plaque comprimising the lumen of the proximal internal carotid artery by only 10% may be considerable despite the absence of a bruit,[1] if the lesion serves as a source of distal emboli (Fig. 2, A and B).

It is revealing to compare the natural history of TIA with surgical results. In an extensive review of extracranial cerebrovascular disease, Clauss and associates[2] compiled data from several sources to show that between 30 and 40% of untreated patients with TIA eventually sustain frank strokes, a rate nearly tenfold that of patients with TIA who undergo appropriate carotid endarterectomy. The incidence of permanent neurologic deficit as a consequence of the operation itself was found to be on the order of 1 to 4%. Thompson and associates[8] recorded their experience with carotid endarterectomy in 592 patients and found that 97% of those whose indication for operation was TIA were improved on late followup and 81% were totally asymptomatic. Only 1% of patients with TIA incurred severe permanent deficits after operation. Thompson concludes with an appeal in favor of prophylactic endarterectomy for significant asymptomatic lesions as well, citing the onset of symptoms in 50% of such patients, if not treated.

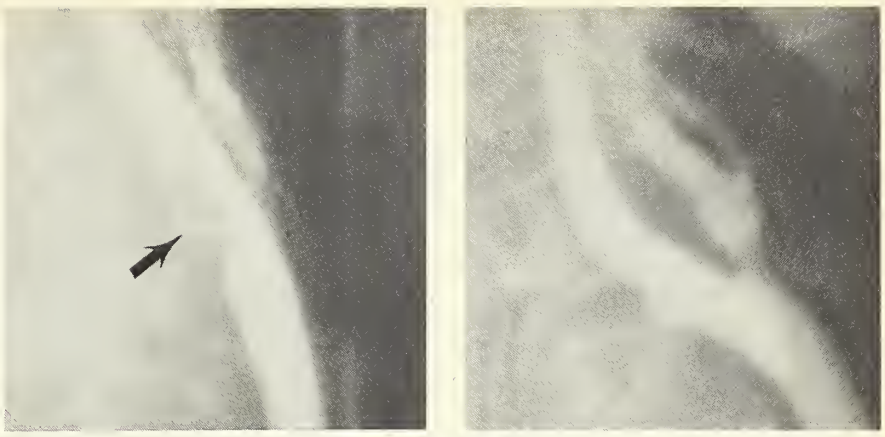


FIGURE 2 A and B

A. Selective carotid arteriogram showing a stenotic lesion at the origin of the internal carotid artery. A central ulceration (arrow) containing contrast medium is demonstrated within the plaque. A lesion of this size might be expected to create a bruit.

B. Selective carotid arteriogram showing an obvious ulceration with no evidence of stenosis. No bruit was present. If this patient had transient ischemic attacks appropriate to the site of the intimal ulcer, carotid endarterectomy would be indicated.

Once a permanent neurologic loss has occurred in a patient with extracranial arteriosclerosis, the risk of postoperative worsening is considerably higher and the late results less impressive than is the case when endarterectomy is done at the earlier stage of embolic TIA.[1,2,6,8] It is now clear that transient cerebral ischemia poses a real threat of subsequent stroke. In a sense, a patient with warning TIA caused by an ulcerated atheroma of the cartoid bifurcation is fortunate since, in general, his complaints are unmistakable, his physical examination revealing, his arteriograms diagnostic and his operation curative. By the same token, a disabling or fatal stroke in such a patient is the more tragic if he told his story, and no one understood.

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SEMINARS FROM



RILEY CHILDREN'S HOSPITAL

RICHARD L. SCHREINER, M.D.
PATRICIA A. KEENER, M.D.
EDWIN L. GRESHAM, M.D.

Indianapolis

Resuscitation of the Newborn

Introduction

THE introduction of intensive care for high risk and low birth weight infants has greatly lowered the overall mortality rate and has also resulted in a dramatic fall in the incidence of long term handicaps such as mental retardation, seizures and cerebral palsy. Favorable outcome depends upon additional factors such as prenatal recognition of potential risk, appropriate intrapartum management, and proper care from the time of delivery. The finest newborn intensive care unit cannot influence the quality of life if irreversible damage has occurred prior to admission.

The importance of proper resuscitation of the sick neonate cannot be overemphasized. The infant who fails to establish adequate respiration at birth will demonstrate serious alterations in his arterial blood gases within a few minutes. The combination of hypoxia, acidosis and inadequate ventilation constitutes an immediate threat to the infant's life. Failure to ventilate adequately the asphyxiated child may result in problems such as a return to a fetal-like circulation where much of the cardiac output bypasses the lungs. The resulting compromise of oxygenation may cause severe central nervous system damage or, in extreme cases, death. Asphyxia is considered by many to be the major cause of perinatal mortality and morbidity.

It is mandatory that every physician involved in the delivery of care of the newborn be competent in neonatal resuscitation since most respiratory emergencies do not permit delay. Other delivery room personnel should also become familiar with the proper techniques of resuscitation since a team approach is often necessary in difficult cases. At the minimum, there should be at least one person—physician, nurse, anesthetist, or respiratory therapist—at each delivery who possesses the knowledge and skill to resuscitate an asphyxiated infant. Likewise, every delivery room should be properly equipped to provide the total support required during a respiratory crisis. Only when this complement of equipment and trained personnel is routinely available in every delivery room will the incidence of neonatal deaths and long term central nervous system disabilities due to acute asphyxia be maximally reduced.

Equipment

A prerequisite to good resuscitation is reliable equipment. In Table 1 is a suggested minimum for every delivery area. Responsibility for the upkeep and periodic inspection of this resuscitation tray must be designated to a specific individual. When this is not done, the "buck gets passed" and too often the set is incomplete or not operational at the time of crisis.

Identification of the High Risk Infant

Oftentimes the need for resuscitation can be predicted before delivery. Some of the factors which are associated with neonatal asphyxia are presented in Tables 2, 3 and 4. Whenever any of these conditions are recognized, advance preparation for possible respiratory support of the infant is indicated.

TABLE 1

Resuscitation Equipment

Overhead radiant heater
Concentrated light source
Source of heated, humidified oxygen
Wall suction
Infant resuscitation bag with face masks (full term and premature)
Laryngoscope with 0 and 1 straight blades
Endotracheal tubes, sizes 10, 12 and 14 Fr. (2.5, 3.0, 3.5 mm) and stylet
Sterile umbilical vessel catheterization tray
3.5 and 5 Fr. umbilical catheters
Sterile suction catheters
Oral airway
Suction bulb

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Supported by The National Foundation—March of Dimes Medical Service Grant #C-117.

TABLE 2

Maternal Factors Associated with Asphyxia at Birth

Maternal disease (renal, pulmonary, cardiac, hematologic, endocrine, infectious, collagen)
Diabetes mellitus
Anemia (hemoglobin less than 10 grams %)
Maternal malnutrition
Maternal drugs (magnesium, ethyl alcohol, barbiturates, narcotics)
History of previous perinatal morbidity or mortality
Less than 16 or greater than 35 years of age
Non-pregnant weight less than 100 pounds or greater than 200 pounds
Surgery in pregnancy
Poor prenatal care
Prolonged rupture of membranes (greater than 24 hours)
Abruptio placenta, placenta previa or other antepartum hemorrhage
Blood type or group isoimmunization
Low urinary estriol
Toxemia of pregnancy, hypertension

tex presentation, bulb suction of the nose and oropharynx should be performed. If there is a history of meconium in the amniotic fluid, the infant is meconium stained, or there is concern about blood aspiration, thorough suctioning of the nose, mouth and pharynx with a bulb or a DeLee mucous trap should be carried out, if possible, before delivering the shoulders. If the baby appears to be severely depressed, e.g., poor color or lack of responsiveness upon delivery of the head, this suctioning should be rapid and not interfere with expeditious delivery of the child.

TABLE 3

Intrapartum Factors Associated with Asphyxia at Birth

Cephalopelvic disproportion
Sedative or analgesic drugs
Prolonged labor (first stage greater than 24 hours, second stage greater than 2 hours)
Precipitous labor (less than 3 hours)
Difficult delivery
Maternal hypotension
Cord compression (nuchal cord, cord knot, compression by head in breech delivery)
Prolapsed umbilical cord
Cesarean section
Breech or other abnormal presentations
Forceps delivery other than low elective

TABLE 4

Fetal Factors Associated with Asphyxia at Birth

Multiple births
Polyhydramnios
Oligohydramnios
Immature L/S ratio
Premature delivery (less than 38 weeks)
Post-term delivery (greater than 42 weeks)
Increased rate of growth (LGA)
Decreased rate of growth (SGA)
Meconium stained amniotic fluid
Abnormal heart rate or rhythm
Fetal acidosis (fetal scalp capillary blood pH less than 7.20)

Evaluation of the Infant

For many years, the Apgar score (Table 5) has been used as a guide in selecting the resuscitative method required for any particular infant. A score of 0-3 indicates severe distress and the need for immediate vigorous resuscitative measures. Infants with Apgar scores of 4-7 are in moderate distress and *might* require vigorous resuscitation. If the score is 7-10, observation is usually all that is required. However, continued close surveillance is very important, even under the most favorable circumstances, since delayed respiratory depression may occur due to drugs, anesthetic agents and a variety of anatomical defects.

The need for immediate intervention frequently cannot wait for assigning a 1- and 5-minute Apgar score. The urgency of the situation can be assessed more rapidly by evaluating two parameters of cardiopulmonary function—respiration and heart rate.

Resuscitation

Guidelines for management based upon a quick assessment of respiratory effort and heart rate are presented in Figure 1. Upon delivery of the infant's head in a ver-

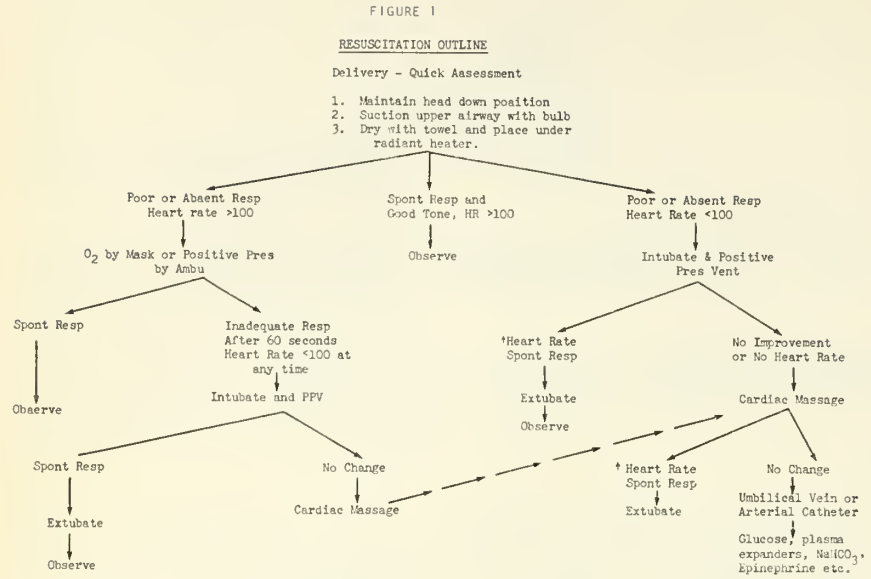
When respirations are spontaneous with no apparent obstruction of air exchange and the heart rate is greater than 100 per minute, close observation is all that is required. If respiratory efforts are inadequate or labored, as evidenced by a lack of spontaneous breathing, gasping or retractions, but the heart rate is greater than 100 per minute, additional measures may be indicated.

TABLE 5

Apgar Score

SIGN	0	1	2
Heart rate	Absent	Slow (below 100)	Over 100
Respiratory effort	Absent	Slow, irregular	Good, crying
Muscle tone	Flaccid	Some flexion of extremities	Active motion
Reflex irritability	No response	Grimace	Vigorous cry
Color	Blue, pale	Body pink, extremities blue	Completely pink

FIGURE 1



The nose and oropharynx should be suctioned with a soft catheter or mucous trap and warm humidified oxygen should be given by mask. The heart rate must be monitored continuously during the period oxygen is being administered, since a falling rate may necessitate more aggressive intervention.

If these procedures do not result in an improvement in respiratory effort, or if the heart rate deteriorates, bag and mask ventilation with supplemental oxygen should be initiated. The infant who has not breathed spontaneously may require initial ventilatory pressures of 50 cm of water to inflate unexpanded alveoli. In most cases, after two or three breaths the delivery pressure need not exceed 20 cm of water. Effectiveness of positive pressure ventilation must be evaluated constantly by observing chest expansion, by auscultation of air exchange and by monitoring the clinical course. Assisted ventilatory rates in excess of 40 per minute are generally avoided so that a sufficient interval is allowed for complete expiration of air. When bag and mask ventilation is used, the tendency to inflate the stomach can be minimized by insertion of a nasogastric tube and/or by gentle abdominal pressure.

If resuscitation by bag and mask does not ventilate the child adequately, the clinical course deteriorates, or the infant is profoundly depressed (i.e., absent respiratory rate and a heart rate of less than 100 per minute), immediate endotracheal intubation should be performed. These severely affected infants are often in shock, as reflected by their extreme pallor and weak pulses. Direct visual assurance that the airway is unobstructed is followed by insertion of the endotracheal tube. If a stylet is utilized, care must be taken to see that it does not extend beyond the tip of the endotracheal tube, since tracheal laceration may result. The most common mistake made during intubation is that the endotracheal tube is inserted too far—usually into the right main stem bronchus. The Cole tube has some advantage for short-term resuscitation, since the flange incorporated into its design does not permit such deep ingress.

When the heart rate is either absent or less than 100 per minute and does not respond to 60 seconds of assisted ventilation, external cardiac massage should be initiated by an assistant. Two fingers are applied just above the heart to the left of the lower sternal border and sufficient pressure is applied for 1 to 2 cm depression. The massage rate should be approximately 100-120 per minute and synchronized so as not to interfere with ventilation. The assisted respiratory rate should be 40 per minute with a ventilation/massage ratio of 1:3 or 1:4. Massage should be stopped periodically to assess spontaneous cardiac activity or improvement in heart rate.

Drug Therapy

If a spontaneous heart rate of greater than 100 per minute is not sustained after three minutes of adequate ventilation and external cardiac massage, chemical treatment is suggested. It is important to emphasize that in most cases drugs are not required to stabilize the patient with acute asphyxia and they never replace ventilation and oxygen therapy. Certain medications such as caffeine and other so-called respiratory stimulants have no place in our armamentarium for acute cardiopulmonary support. They are not only ineffective but their side effects may further endanger the patient's already precarious status. When drugs with recognized effectiveness are necessary during resuscitation, they are usually administered by an umbilical vein catheter passed, if possible, into the inferior vena cava. Table 6 lists the drugs, indications for use, routes of administration, and the order in which they are usually given.

Hypotensive infants may be recognized by pallor, mottling of the skin and poor capillary filling, as well as measured low blood pressure. The child who is hypotensive due to asphyxia or acute blood loss should receive either whole blood or other volume expanders. When blood is not immediately available, preparations such as Plasmanate,* Plasmatein,** plasma or 5% albumin solutions should be administered at 10-20 cc per kg over five minutes.

Stressed infants rapidly exhaust their glycogen stores and thereby

*Cutter Laboratories, Berkeley, California.

**Abbott Laboratories, Chicago, Illinois.

TABLE 6

Drugs in Resuscitation

DRUG	INDICATION	ROUTE OF ADMINISTRATION	DOSE
Whole blood or 5% protein solution	History of blood loss, shock, hypotension	IV	10-20cc/Kg
$D_{25}W$	Asphyxia	IV	4cc/Kg over 5 minutes
Naloxone	Maternal narcotic administration and neonatal depression	IV	0.01mg/Kg
$NaHCO_3$ (.88 or 1.0mEq/cc)	Severe metabolic acidemia or Severe asphyxia not responsive to routine resuscitation	IV	1-2mEq/Kg over 5 minutes. Dilute 1:2 with sterile water
Epinephrine 1:10,000	Cardiac arrest, severe bradycardia not responsive to routine resuscitation	IV (while performing cardiac massage) or intra-cardiac injection	0.1-0.3cc/Kg of 1:10,000 solution
Ca Gluconate 10%	Severe bradycardia	IV	1.0cc/Kg slowly
$CaCl_2$ 10%	Severe bradycardia	IV	0.1cc/Kg slowly

have an impaired ability to maintain glucose homeostasis. To avoid this complication in very sick infants, a 10% glucose solution is started intravenously. In the severely depressed baby it may be necessary to administer 4 cc per kg of 25% dextrose in water by slow push infusion.

When narcotic analgesics given to the mother could be contributing to the child's respiratory embarrassment, intravenous naloxone may be beneficial. Naloxone is now available in a pediatric dose vial and it is preferred over nalorphine because of the latter's potential respiratory depressing effects.

Nearly all asphyxiated infants have both respiratory and metabolic components to their acidosis. Respiratory acidosis is alleviated by adequate ventilation. Since the metabolic portion is caused and perpetuated by hypotension and hypoxia, it is very important to relieve these factors by methods previously described. In cases of severe or prolonged asphyxia, 1-2 mEq per kg of sodium bicarbonate diluted to 0.3-0.5 mEq per cc with sterile water is given by slow infusion, i.e., over five minutes. Faster infusion rates or use of more concentrated solutions may result in serious hyperosmolar damage. Subsequent bicarbonate therapy should be administered more precisely based upon quantitated blood acid-base studies.

The most common indicators for aqueous epinephrine are cardiac arrest and severe bradycardia not responsive to routine resuscitation. It should be administered either intravenously or by the intracardiac route. When given I.V. and perfusion is poor, it may be necessary to initiate cardiac massage to hasten the pharmacologic effect. The standard dose is 0.1-0.3 cc per kg of a 1:10,000 dilution given after the bicarbonate injection. Calcium gluconate or calcium chloride may be necessary in cases where severe bradycardia persists despite the previous therapeutic measures.

TABLE 7

Management of Meconium Staining in Delivery Room

1. Before delivering shoulders thoroughly suction the nose, mouth and pharynx.
2. Immediately after delivery of the infant repeat suctioning of upper airway, dry rapidly and place under radiant warmer.
3. If baby is depressed or shows signs of respiratory difficulty, aspirate trachea with mouth-to-endotracheal tube suction.
4. Repeat suction until trachea clear of meconium (<60 seconds).
5. Ventilate and resuscitate.
6. Aspirate meconium from stomach.

Management of the Meconium Stained Infant

The meconium stained child with respiratory distress presents a special problem in resuscitation. This complication has a 20-50% mortality rate which is very much influenced by management. A brief guide to the emergency care of this disorder is presented in Table 7.

When confronted with a cyanotic, apneic or flaccid newborn infant, our first inclination is to provide ventilatory assistance. This tendency must be modified when aspiration is suspected, for ventilation without clearing the airway will quite likely result in death. Any child who is meconium or blood stained should have rapid but careful suctioning of the mouth and nose upon delivery of the head. Immediately after delivery, the upper airway should be aspirated again, and if there is any indication of respiratory distress or depression, deep suctioning of the trachea should be performed under direct laryngoscopy. This can be accomplished by means of a DeLee catheter or via mouth-to-endotracheal tube suction and should be

repeated until the aspirate is clear. Since the child may well be deteriorating during this important initial step, the entire procedure should take no more than 60 seconds. Only after the meconium has been cleared from the trachea should ventilation by bag and mask or by endotracheal tube begin. An assistant who is monitoring elapsed time and the child's heart rate is vital so that each step is accomplished without undue delay. Aspirating the stomach of all babies who are meconium stained is also important to minimize the risk of repeated aspiration of regurgitated debris.

Epilogue

Care of the resuscitated infant does not end after emergency resuscitation. Continued close monitoring of temperature, respiratory rate, heart rate, blood pressure, glucose, pO_2, pH, pCO_2, hematocrit, etc. is required in every infant severely depressed at birth. Appropriate attention to the stability of vital functions and metabolism is essential for early recognition and correction of the many sequelae which can occur after periods of significant stress. Only with structured programs which train personnel and maintain their proficiency in both acute and convalescent management of neonatal asphyxia can the ultimate goal of eliminating preventable causes of psychomotor retardation be achieved. ◄

From the Transactions of the Indiana State Medical Society

100 Years Ago

Tobacco has been used in the treatment of a great variety of diseases.

The following is a list of them, compiled, as in fact the whole article is, from Stille's and Eberle's Therapeutics, the United States Dispensatory, Chemistry of Common Life, several monographs on tobacco, and from experimental practice, viz:

Obstinate constipation and obstructions in the bowels. A variety of skin diseases, as erysipelas, scabies, psora, taenia capitis, etc.; obstinate intermittents, dropsy, dysuria, dysentery, nephritic calculous, spermatorrhoea, balanitis and incipient gonorrhoea; to remove worms from the bowels, and in tropical latitudes the smoke has been forced into the antrum of Highmore to remove worms from thence; cholera-morbus, colica pictonum, strangulated hernia, tetanus, epilepsy, asthma, spasmodic croup, whooping cough; as an expectorant in bronchial catarrh; as a relaxant in cases of luxation of joints and other spasmodic diseases, and spasms of muscle, and a general aperient.

It has been used to cure prurigo, pityriasis, gout and articular rheumatism, old chronic sores, toothache, nasal polypus, pyrosis; as an antidote to the poison of the rattlesnake and other venomous reptiles and insects, and the poison of mushrooms and opium. Tobacco smoke has been forced into the eustachian tube to cure catarrh of the internal ear. It has also been swallowed to cure chronic singultus with the effect of giving relief after other remedies had failed. It has also relieved asphyxia from drowning, given in the form of both the smoke and the infusion.

In all the above named diseases it has proven more or less beneficial when it has been used in a very weak form, but it has often proven a fatal remedy in nearly all kinds of diseases for which it has been administered. The most dangerous manner of using it has been by injection into the rectum of the solution of the active properties in water, or an infusion of tobacco. It has frequently proven a fatal agent applied to the skin, either the moistened leaves or an infusion or ointment. It produces fatal prostration and direct poisoning.

The only cases in which I have known it to produce positive benefit, without any evil, were the rattlesnake bites, bee stings, rashes on the skin produced by parasites, as lice and ticks, and balanitis or the first indication of gonorrhoeal inflammation of the glans penis and prepuce, and in one case of dropsey. . . . **"Tobacco: Its Properties and Uses,"** William F. Harvey, M.D., Plainfield, 1876.

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Each capsule contains 50 mg. of Dyrenium® (triamterene, SK&F Co.) and 25 mg. of hydrochlorothiazide.

MAKES SENSE FOR LONG-TERM CONTROL OF HYPERTENSION*



Before prescribing, see complete prescribing information in SK&F Co. literature or PDR. A brief summary follows:

* WARNING
This fixed combination drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

* **Indications:** When the fixed combination represents the dosage determined by titration: Adjunctive therapy in edema associated with congestive heart failure, hepatic cirrhosis, the nephrotic syndrome. Corticosteroid and estrogen-induced edema, idiopathic edema; hypertension, when the potassium-sparing action of its 'Dyrenium' component is warranted.

Contraindications: Further use in progressive renal or hepatic dysfunction; hyperkalemia. Preexisting elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs. Routine use of diuretics in otherwise healthy pregnancy.

Warnings: Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in severely ill patients with urine volume less than one liter/day, the elderly or diabetics, with suspected or confirmed renal insufficiency. Periodic determinations of serum K^+ should be made. If hyperkalemia develops, substitute a thiazide alone, restrict K^+ intake. **The presence of a widened QRS complex or arrhythmia in association with hyperkalemia requires prompt additional therapy.** Thiazides are reported to cross the placental barrier and appear in breast milk; fetal or neonatal hyperbilirubinemia, thrombocytopenia, altered carbohydrate metabolism and other adverse reactions that have occurred in the adult may result. When used in pregnancy or in women who might bear children, weigh potential benefits against possible hazards to fetus. Adequate information on use in children is not available.

Precautions: Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics, or those with suspected or confirmed renal insufficiency. Watch for signs of impending coma in severe liver disease. If spironolactone is used concomitantly, determine serum K^+ frequently; both can cause K^+ retention and elevated serum K^+. Two deaths have been reported with such concomitant therapy (in one, recommended dosage was exceeded, in the other serum electrolytes were not properly monitored). Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving Dyrenium® (triamterene, SK&F Co.), and leukopenia, thrombocytopenia, agranulocytosis, and aplastic anemia have been reported with thiazides. Do periodic blood studies in cirrhotics to check for nondrug-related variations in blood pictures, and in patients with folic acid depletion, since 'Dyrenium' may contribute to appearance of megaloblastosis. Antihypertensive effect may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine.

Adverse Reactions: Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances. Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and, rarely, allergic pneumonitis have occurred with thiazides alone.

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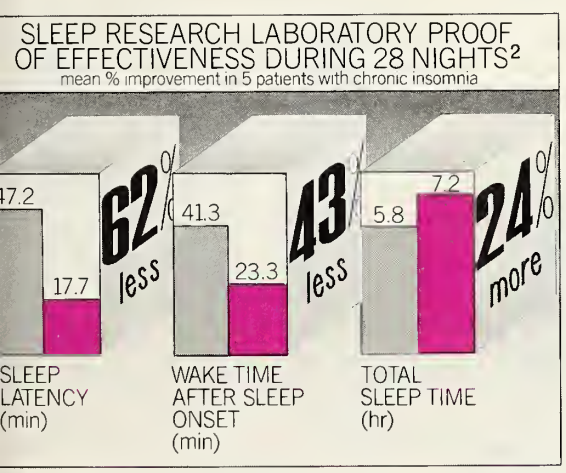

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For insomnia that is a chronic problem...

Only Dalmane (flurazepam HCl) offers sleep laboratory proof of effectiveness for as long as 28 nights

Continued relief of insomnia in patients with chronic insomnia

Since insomnia is often transient and intermittent, the prolonged administration of a hypnotic is generally not necessary or recommended. But when insomnia is a chronic or recurring problem, continued effectiveness is as important as initial effectiveness. Results of a recently published sleep research laboratory study[1] demonstrated that, while pentobarbital lost effectiveness within two weeks, Dalmane maintained effectiveness for 28 consecutive nights. Similar 28-night results with Dalmane, displayed below, were obtained by a second sleep research group.[2] In previous studies,[3] both chloral hydrate and glutethimide began to lose effectiveness after several nights, while Dalmane maintained effectiveness throughout the 14 medication nights. Whether the problem is difficulty falling asleep, staying asleep or sleeping long enough, consider these results when selecting a sleep medication.



Patient benefits include relative safety, infrequent morning "hang-over"

Dalmane is well tolerated, seldom causing morning drowsiness or grogginess.[4] No increase in dosage is required for continued effectiveness from night to night.[1-3] Should Dalmane be used repeatedly, periodic blood counts and liver and kidney function tests should be performed. The usual adult dose is 30 mg *h.s.*, but 15 mg may suffice for some patients and is recommended as a starting dose for the elderly and debilitated to help preclude oversedation, dizziness or ataxia.

Continued relief of insomnia: One more good reason to specify

Dalmane®
(flurazepam HCl)

One 30-mg capsule *h.s.*— usual adult dosage (15 mg may suffice in some patients).
One 15-mg capsule *h.s.*— initial dosage for elderly or debilitated patients.

whenever a hypnotic is needed

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Please see following page for a summary of product information.

Objective proof: continued insomnia relief without increasing dosage...[1,2]

Dalmane® (flurazepam HCl) Ⓒ IV

Objectively proved in the sleep research laboratory...

during 28 consecutive nights of administration:

- ☐ **effectiveness with a single 30-mg *h.s.* dose, maintained**
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- ☐ **sleep for 7 to 8 hours, on average, maintained**
- ☐ **less time awake during the night, maintained**

Before prescribing Dalmane (flurazepam HCl), please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended.

Contraindications: Known hypersensitivity to flurazepam HCl.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Several studies of minor tranquilizers (chlordiazepoxide, diazepam, and meprobamate) suggest increased risk of congenital malformations during the first trimester of pregnancy. Dalmane, a benzodiazepine, has not been studied adequately to determine whether it may be associated with such an increased risk. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated, limit initial dosage to 15 mg to preclude oversedation, dizziness and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in patients who are severely depressed, or with latent depression or suicidal tendencies. Periodic blood counts and liver and kidney function tests are advised during repeated therapy. Observe usual precautions in presence of impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity, and elevated SGOT, SGPT, total and direct bilirubins and alkaline phosphatase.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg initially until response is determined.

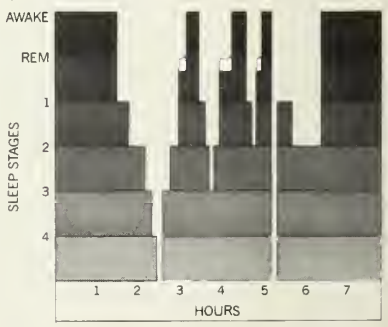
Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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2. Dement WC, *et al*: Long-term effectiveness of flurazepam 30 mg *h.s.* on chronic insomniacs. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, Jun 30-Jul 4, 1975
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4. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ

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DES Therapy Follow-Up Recommended

THE National Cancer Institute is supporting a study of vaginal cancer and also noncancerous genital tract irregularities in offspring of mothers who received synthetic estrogens during pregnancy.

Diethylstilbestrol or stilbestrol (DES) was prescribed during the 1940s for complications of pregnancy such as bleeding, threatened miscarriage, toxemia or diabetes. Clinical experience, later in the era, showed that the results were not as good as originally thought. As newer compounds became available, the use of DES in pregnancy soon diminished.

In 1971 it was reported that there was a link between DES therapy in pregnancy and the later occurrence of clear-cell adenocarcinoma of the vagina in female offspring exposed to the drug *in utero*.

This report has been confirmed by many others. In addition, recently reports have appeared to the effect that, while male offspring have not developed neoplasms, there is a similar link with the development of urogenital abnormalities, such as urethral stenosis, in male offspring of DES-treated mothers.

The patients reported to date have varied in age from 7 to 28 years. All the patients with clear-cell vaginal adenocarcinoma and many of the DES-exposed offspring without adenocarcinoma have been found to have benign adenosis of the vagina.

Factors other than maternal hormone administration may play a role in these tumors, but 80% of the patients with vaginal adenocarcinoma are known to have been exposed to DES-type hormones.

In all reported cases in which treatment dates are determinable, the drug was given before the 18th week of pregnancy. Small doses over a long time, or larger, though not unusually large, doses over a short period have both been associated with the neoplasms.

All asymptomatic girls who were exposed *in utero* should receive a thorough pelvic examination at menarche or if they have reached 14 years of age. Younger girls should be examined if they develop abnormal bleeding or discharge. Prior to examination, the procedure should be discussed with the patient and with her mother or father if she is a minor.

The examination should include inspection and palpation, Pap smear, and an iodine staining test of the cervix and vagina. Abnormal areas, including areas that do not stain with iodine, should have specimens removed for biopsy. Colposcopy is useful but not essential.

Patients exposed to DES-type drugs should be followed on a regular basis.

Both surgery and high energy

radiotherapy potentially can cure the carcinoma, with early diagnosis and early treatment giving the best results. Such findings as squamous dysplasia or carcinoma in situ should be treated in the usual manner.

There is no evidence to date to indicate that use of oral contraceptives by the DES-exposed population would be undesirable. The presence of adenosis is in itself no contraindication to future pregnancy.

Physicians may utilize the attached card to request free copies of three publications on this subject.

Guest Editorial

Today's Stamp Acts Cost A Lot More

THE food stamp program was supposed to bring an adequate diet within reach of those Americans too poor to pay for one. In addition to its original worthy purpose, it is now subsidizing the food budgets of well-paid union workers out on strike, teachers on summer vacation, college students whose parents can well afford to feed them, and families with incomes as high as $16,000 a year (or even higher, since there is no theoretical limit to the gross income a food stamp recipient may receive).

The rolls of food stamp recipients have grown from 367,000 in 1964 to nearly 20 million today. Officials foresee the number of those eligible rising to 60 million in a year or so. The program has become a guaranteed annual income, provided in kind rather than in cash.

The truth is, this type of subsidy program constitutes both bad economic policy and bad welfare policy.

It is bad welfare policy because it implies that the government is better able than the recipient to decide how public aid should be spent by the recipient; because it channels to the comparatively well-off money that could otherwise go to the truly needy; and finally, because it distorts our information on the extent of poverty. This last point arises because a family receiving aid under several different welfare programs—say, housing assistance, AFDC payments, and food stamps—may be receiving the equivalent of $10,000 or $15,000 a year, and yet still be classified below the "poverty" line based on "income" alone.

The economics are even worse. First, if the money taken from the private sector by the government for these programs was left instead in the private economy, it could be invested in the creation of productive jobs—a much better way to help the able-bodied welfare recipient.

Second, consider the insanity of this: The Federal Government is taxing money from people in the $5,000 to $15,000 a year brackets, running it through Washington, where administrative costs eat up nine to 14 cents of the food stamp dollar, and then returning it to some of these same people in the form of a federal subsidy. Wouldn't it make more sense to lower the tax rate and let people keep—and spend—their own money?

—Richard L. Lesher, President, Chamber of Commerce of the United States.

Editorial Notes . . .

Research at The Upjohn Company laboratories has discovered an oral agent that stimulates cells to produce interferon against viruses in a number of species and in both tissues in culture and living animals. Since the agent is active in tissue culture it may find use as a tool to investigate the mechanism by which cells produce interferon.

Congress has passed and the President is expected to sign a bill which will make action filed against the United States the sole remedy for malpractice allegations arising from activities of physicians, dentists and supporting health personnel of the armed services on active duty within the scope of their professional duties. (H.R. 3954, the Military Medical Malpractice Bill.)

The American Red Cross has, for reasons of its own which are hard to understand, cancelled the cooperative agreement of 16 years' standing which has facilitated the exchange of blood credits from bank to bank. Hereafter blood banks maintained by the Red Cross will not exchange blood or blood credits with banks maintained by the American Association of Blood Banks.

Drug and pharmaceutical prices rose only 0.2% from August to September, compared to 0.9% rise for all commodities. Chemicals and allied products, of which pharmaceuticals are a subgroup, increased at twice the drug rate—0.4%.

Naprosyn, an antiarthritic, was discovered by Syntex, and since 1969 has recorded an estimated 120 million patient-days of use without any reported significant ill effects. Recently the FDA discovered that rat toxicity studies done between 1969 and 1971 were not satisfactory to the FDA and, as a consequence, the agency has chosen to ignore the long and exemplary record of clinical use in humans and has announced that it will remove the drug from the market. Syntex will demand a formal hearing. The rat studies in question are not required by regulatory agencies in 39 of the 40 countries in which Naprosyn is marketed. Approval in the 39 countries is based on other animal toxicity studies and clinical data.

The Pharmaceutical Manufacturers Association is asking permission to appear before the Pharmaceutical Reimbursement Advisory Committee in order to present testimony in regard to inclusion of certain drug forms in the MAC price ceiling. The

Association has doubts concerning bioequivalence of the drugs under consideration and also feels that the committee has not obtained the proper economic data.

The FDA has commissioned several panels of experts to examine and report on the desirability of continuing over-the-counter (OTC) sale of drug products. The Panel on Antacids, among other products, examined Alka-Seltzer®, a combination of aspirin with an antacid, and recommended approval for symptoms such as acid indigestion and headache requiring antiacid and analgesic ingredients. Lately, the Analgesic Panel has been critical of Alka-Seltzer because it contains aspirin which, the Panel says, may be harmful under a wide variety of circumstances. All this, despite the fact that buffered aspirin has long been considered the best form of aspirin to take because of rapid absorption and reduced gastric irritation. The Analgesic Panel Report is preliminary and may be altered after public comment is received by FDA.

The VA has just dedicated a huge new hospital in West Los Angeles constructed to resist an earthquake up to 8.5 on the Richter scale. It will be able to continue to operate for four days without city water, electrical or sewage services. The 20-acre hospital site has been planned so that it will be capable of serving as an emergency medical center in event of disaster. ◀





Five hundred and twelve delegates from 53 countries met for four days in New York City, but there were no smoke-filled rooms.

The meeting was the third World Conference on Smoking and Health, and the delegates reaffirmed the evidence that cigarette smoking is "the single most preventable cause" of lung cancer, heart disease and a number of other serious disorders.

The Conference, sponsored by ACS and NCI in cooperation with 10 other health agencies, was carrying on the work begun at two previous world parleys, 1967 and 1971. Particularly newsworthy was the fact that now women and young people are smoking more in a number of Western countries, and the death rate from lung cancer for women in the US has more than doubled in the last decade.

The rise in smoking by women came under close scrutiny, and one aspect was smoking by pregnant women. Dr. Neville R. Butler of the Royal Hospital for Sick Children in Bristol, England, cited 40 studies showing that women who smoked during the last half of pregnancy were likely to reduce the size of their babies and increase the chance of stillbirth. Dr. Butler said 4,600 deaths of newborns each year in the U.S. were due to women smoking during pregnancy.

Delegates called for an end to government tobacco subsidies and recommended that cigarette taxes be raised progressively to discourage consumption and help fund antismoking programs. A levy of one cent per pack was suggested for the U.S.

Delegates also urged that Sweden's comprehensive plan to create a nonsmoking generation, beginning with babies born in 1975, be studied as a model that could be adapted for use in other countries. The Swedish plan will follow the present generation through its formative years, weeding out influences that might turn them into smokers. Long-range planning includes banning all cigarette advertising and, by 1979, discontinuing all cigarette vending machines. Smoking will be prohibited in working areas and in a growing number of public places.

Sweden is not alone in its antismoking campaign. Neighboring Norway has just passed a stiff Tobacco Act, which bans all tobacco advertising and requires a strong warning on cigarette packs. But, of 100 countries surveyed by the World Health Organization, 70 have no anti-smoking legislation at all.

Along with warnings about the dire consequences of smoking, the conference held out considerable hope for those who quit, citing additional evidence that cells can recover from smoke-inflicted damage. The message was clear: As long as irreversible disease has not already set in, it's never too late to quit.

The relationship between tobacco smoking and disease, disability and mortality is of international concern. Activities to elucidate etiological connections are taking place in all countries where tobacco is smoked. And a host of ancillary programs in pharmacology, cessation, education, politics and legislation are continually developing, worldwide.

In effect, health, education and political institutions in the leading countries are mounting an unorganized movement, or series of parallel advances: a fight against the individual health hazards and social costs of smoking.

In any such effort communications are vital. To know what is happening—what works and what doesn't—saves time and money and effort. Until now, the only ongoing international means of communication devoted to these subjects has been the three quadrennial World Conferences on Smoking and Health sponsored by the ACS in New York City.

At that Third World Conference participants voted to establish a publication as a means of communication at more frequent intervals. The Board of Directors of the ACS heeded this request and voted a budget to establish this journal, which, in the beginning, will be published two or three times a year. WORLD SMOKING AND HEALTH is being distributed free by the ACS.

Contents of the first issue include:

"Behavioral Research in Smoking Withdrawal"—Martin Raw, England

"Smoking Cessation Through the Use of Cytisine and Other Chemotherapy"—Josef Granatowicz, Poland

"The Bornholm Experiment"—Kasper Vilstrup, Denmark

"A Critical Review of the Effect of Nicotine and Carbon Monoxide on Coronary Heart Disease"—Wilbert S. Aronow, USA

"Smoking in the Cockpit, and Smoking by Flight Crewmembers Before Commercial Flight Operations"—Airline Pilots Committee, USA

"New Ideas in Sweden's Tobacco Labeling Act"—Lars M. Ramstrom, Sweden

"An Overview: Health Consequences of Smoking"—Department of Health, Education, and Welfare, Public Health Service, USA

"Smoking and Lung Cancer, AUICC Project"—Nigel Gray, International

"Changes in Non-Smokers Saliva Thiocyanate Levels After Being in a Tobacco Smoke-Filled Room"—T.J. Pekkanen, O. Elo, M.L. Hanninen, Finland

"Some Recent Findings Concerning Cigarette Smoking"—C. Cuyler Hammond, Lawrence Garfinkle, Herbert Seidman, Edward A. Lew, U.S.A.

Copies are available through the Indiana Division of ACS.

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WILLIAM M. DUGAN, JR., M.D.
President, Indiana Division
American Cancer Society

Letters

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George M. Rosenheimer, M.D.
C/o The Journal
Dear Dr. Rosenheimer:

Your excellent article on the history of anesthesia in Indiana in the July issue of *The Journal of the Indiana State Medical Association* contains an inaccuracy which concerns the priority of chloroform anesthesia for a major operation. We physicians of LaPorte County feel you would wish to be apprised of this oversight.

You state that the first probable use of chloroform anesthesia in Indiana was given for the famous "cholecystotomy" done by Dr. J. A. Bobbs of Indianapolis. We would point out that chloroform anesthesia was reported in lurid prose in the descriptions of operations done at the Indiana Medical College at LaPorte as early as 1849. The *LaPorte County Whig* carried accounts of operations, including the removal of the tibia for osteomyelitis in a 19-year old, removal of an ovarian tumor weighing over 40 pounds, excision of the mandible for osteosarcoma in a 17-year old boy and cataract surgery. These procedures under chloroform antedated the cholecystotomy by 20 years.

Another noteworthy achievement is that of Dr. George Andrew of LaPorte. After attending a demonstration at Massachusetts General Hospital he conceived and had constructed by a tinsmith a rudimentary ether mask which he used to anesthetize his wife with that gas at the time of the delivery of their child in 1847.

The life of the Indiana Medical College was evanescent and its doors closed in 1850. William Henry Wishard of Indianapolis (the father of William Niles, Sr.) and W. W. Mayo (the father of Charles and William) were graduates. Dr. Wishard is said to have given a chloroform anesthetic in 1851 at Greenwood, Indiana.* Although it was unusual around Indianapolis and the family refused permission, the patient was of age and agreed. As he was comoing out of the anesthetic he was confused and the doctors were accused of destroying his reason but the patient later was quite satisfied. So you can readily understand that there were general anesthetics with both chloroform and ether given in Indiana prior to the case cited in your article.

RODNEY A. MANNION, M.D.
BARBARA M. BACKER, M.D.
LaPorte

To the editor:

I wish to thank Drs. Mannion and Backer for their letter of August 20th, giving the data on earlier anesthetics than I presented in my paper.

As I mentioned in the closing of the paper:

> "I have attempted to produce some facts and reminiscences of interest of early anesthesia in Indiana, but there will be mistakes and many omissions due to lack of data."

If anyone has additional information of any very early anesthetic given in their area, please contact me, giving the anesthetic, who administered it and the date, and the procedure done.

If I should receive enough additional data, I would be glad to write a supplement to my paper and submit it for publication to our Journal.

G. M. ROSENHEIMER M.D.

To the editor:

I am interested in finding the incidence of allergic reactions to chocolate because of a recent query I received from a chocolate manufacturer.

I would appreciate hearing from physicians the estimated number of their patients allergic to chocolate, and the symptoms produced. I would also appreciate receiving specific case reports, results of laboratory tests, and any other comments on the subject.

Thank you very much.
CLAUDE A. FRAZIER, M.D.
Doctors Park #4
Asheville, N.C. 28801

To the editor:

The Rightful Role of the Physician
—Who's Determining It?

As the final class of Physician's Assistant students enters their last phase of training, I am deeply concerned about the practice of medicine as they will find it when they graduate. My concerns are not so much about their eventual role in the health care team, though this aspect worries me, but more so, what kind of health care will patients be receiving and who will be "running the show."

The leader of any health team has traditionally been the physician. S/he has always made the final decision on a patient's management, but this situation is changing rapidly. We see nurses gaining the legal right to practice nursing management in several states including Indiana. Although the term "nursing

One Hundred Years of Medicine, Indianapolis, 1820-1920, Thurman B. Rice, M.D., from *Indiana Medical History Quarterly,* Vol. II, No. 3, pp. 40-44, January 1976.

management" is ill-defined, it seems to give the nurses an independent role in the area of patient management heretofore reserved only for physicians. Further, the nurses are not alone in their quest to reshape the physician's role.

All of the independently licensed health professions have, in a way, taken over part of the role of the physician. I now wonder if the patient can adequately distinguish between the optometrist and the ophthalmologist; the podiatrist and the orthopedic surgeon; or the chiropractor and the neurologist. For example, how often have you heard patients refer to their optometrist as the eye doctor; or their podiatrist as the foot specialist?

I recently read, with empathy, a story written by a distressed ophthalmologist in West Virginia. He was amazed to discover that his state's legislature had recently given the right to prescribe medication for eye disorders to optometrists. This action occured even though the state's medical association had actively opposed its passage. Why do such things happen and can this reversal of roles be stopped?

Having been involved in four unsuccessful attempts at getting P.A. legislation enacted in Indiana, I am amazed at the lack of influence organized medicine has on our legislative process. Perhaps more precise, I am amazed at the influence that organizations representing non-physician health care providers have on changing the way in which health services are delivered.

Whether or not one agrees with the Physician's Assistant concept, this negative legislative history points out one fact, physicians must again assert their rightful role of directing the health care system. This system can not continue to experience the fragmentation of delivery mechanisms we are now seeing without serious consequences, one of which is the shift of control of health care from the physician to the federal government.

However, the most serious consequence I fear is one of reduced quality care being delivered to the patient. Can a patient receive high quality medical care when one type of provider is independently responsible for his eyes, another for his feet, another for his spine, while *no one* maintains overall responsibility for his total care? This is the question that will need to be answered if the physician does not remain in complete control of the health care team.

Physicians *must* make their voices heard at the State House. All non-physician providers should be made responsible to the physician for services they render, and laws should be enacted to assure this end. This will maintain the delivery of continued high quality health care to the people of Indiana.

DAN P. FOX, P.A.C
Director, Physician Assistant Program, Indiana University School of Medicine, Fort Wayne

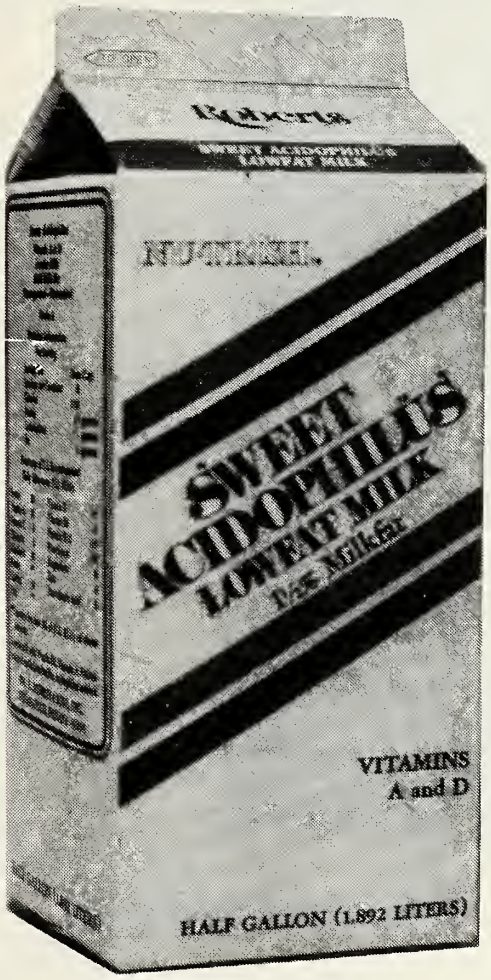
Editor's Note: Federal Regulations, now in effect, direct that physical therapy technicians may submit bills, in their own name, for their personal services to patients under Medicare and Medicaid, without ratification by the physician who prescribes the therapy.

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INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated) for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection.

Prophylactically, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing. **CONTRAINDICATIONS:** Not for use in the eyes or external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of the components. **WARNING:** Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended. **PRECAUTIONS:** As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs. **ADVERSE REACTIONS:** Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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BOOK REVIEWS

DIABETIC COOKING MADE EASY

V. Donahoe, Burgess Publishing Co., Minneapolis, 1973.

Diabetic Cooking Made Easy bears the authoritative endorsement of the American Diabetes Association. It is, in essence, a practical guide for preparing attractive, tasty meals for those on a diabetic diet. Written by an author who has diabetes, the book is, therefore, doubly valuable. Its attractive recipes present the number of servings or units, the exchange value, and the calories of each serving or unit. Ms. Donahoe explains the basic elements of the diabetic diet and offers a variety of recipes for sauces and dressings, molded salads, main dishes and desserts. The book is attractively illustrated in color, is paperback with a loose-leaf plastic binding, has some 70 pages and an index, and sells for $3.95.

W. D. SNIVELY, JR., M.D.
Evansville

FREEDOM TO DIE

O. Ruth Russell, Dell Publishing Co., New York, 1975; price $1.95.

As the claims on the cover of this book suggest, it is a well researched and organized effort complete with index, a listing of euthanasia court cases, 29 pages of references, and an appendix including the Hippocratic Oath, various legislative proposals, the Living Will and a series of definitions of death.

The body of the book begins with a review of current attitudes toward death and dying in modern society. This is followed by an historical review of the use of euthanasia both in Europe and the United States. The final section includes a question-and-answer approach to the arguments *against* euthanasia as well as current euthanasia legislation.

O. Ruth Russell is professor emeritus of psychology at Western Maryland College and a former student of Alfred Adler (the latter fact may contribute to the author's emphasis on the need for greater individual assertiveness on this issue).

By the end of the first chapter the reader is quite aware the author is promoting *active* euthanasia and the slant of the rest of the book makes no secret of this view. "The fact is that many people will go on suffering in great distress and indignity unless active steps are taken to induce death." (p. 34)

The terminology surrounding the topic of euthanasia is complicated and even misleading unless one carefully understands what he/she means by the words being used. Dr. Russell is quite clear where she stands and her book is certainly a valuable resource for anyone interested in this issue.

Nevertheless, the questions and controversies about euthanasia, active and passive, "death with dignity," living wills and so on, will not be settled by this book. The topic is simply too complex and too morally important to be solved facilely.

Questions about maintaining necessary safeguards for the patient, the right to "induce" death, the role of the doctor in making death-promoting decisions, the role of the Church—

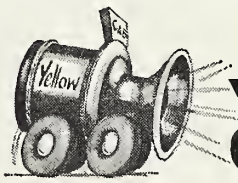
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Where people come first

and specifically Roman Catholicism—in discussing the morality of euthanasia are treated in this book. The author's bias does prevent this work from being an objective endeavor. This leaves the reviewer disappointed because the book has much factual information which would be more helpful for informed discussion about euthanasia if it were stated in a more open and objective style.

It is misleading to make the issue into one of the Church versus "humane treatment." Legal permissibility for euthanasia is an ongoing issue which no society should take lightly, because what is eventually decided in law will say more about us as a people than about our legal system. The Church is the people of God and not some cold, impersonal decision-maker. Its concerns are the peoples' concerns.

Keeping the author's bias in mind, one would find this book stimulating reading in the process of knowing how to truly respect life. It is a good resource for the ongoing discussion of our growing control over life and death.

ROBERT J. ROSS, S.J.
Chaplain, St. Vincent Hospital
Indianapolis

SO GET ON WITH IT

M. Weisman, J. Godfrey, Doubleday & Co., New York, 1976.

So Get On With It, by Marilee Weisman and Jan Godfrey, is a heartwarming book concerned with sports for the physically disabled. What started almost 30 years ago as a novel form of physical therapy has burgeoned into a worldwide activity involving thousands of people in more than 60 countries. In a word, So Get On With It presents the reader with a revealing look at these people and at their accomplishments. The book is virtually a photographic album, and the photographs are very well done. In addition to being the first of its kind, the book should provide inspiration and richly deserved recognition for people confined to wheelchairs, with the emphasis on courage and ability rather than on disability. The book is published by Doubleday & Company, is hard cover, and sells for $8.95. It is strongly recommended for anyone concerned with the disabled.

W. D. SNIVELY, JR., M.D.
Evansville



GANJA IN JAMAICA: THE EFFECTS OF MARIJUANA

V. Rubin and L. Comitas, Anchor Press, Garden City, N.Y., 1976.

Ganja In Jamaica is, in truth, a defense of the use of marijuana. It is not, however, to be lightly dismissed, since it is sponsored by the Center for Studies of Narcotic and Drug Abuse and the National Institute of Mental Health. While it does present objectively the pros and cons of the use of marijuana, it is chiefly pro. It points out that in Jamaican society marijuana is widely used and that there is little correlation between the use of marijuana (they call it ganja) and crime. There were no indications of organic brain damage or of chromosome damage, and there were no significant clinical differences between smokers and nonsmokers. The single medical finding of interest was the indication of functional hypoxia among heavy, long-term chronic smokers. As the chairman of the National Commission on Marijuana and Drug Abuse, former Governor of Pennsylvania Raymond Shafer, points out, "There are always risks inherent in the use of any 'drug,' including aspirin, and non-adaptive uses and pathological reactions may occur." The book covers such topics as the ethnohistory of marijuana, legislation, clinical studies, respiratory studies, psychologic studies and, finally, the relationships between marijuana, society and culture. The book, which is paperback and sells for $2.95, is recommended only for those physicians particularly interested in marijuana use.

W. D. SNIVELY, JR., M.D.
Evansville

A NEW VACCINE FOR CHILD SAFETY

M. Harmon, Safety Now Co., Jenkintown, Pa., 1976.

What author Murl Harmon is talking about in this attractive, illustrated, well written little book is not indeed a vaccine, but rather a host of common sense rules for the prevention of childhood accidents. The book covers such matters as starting safely in the first year, the hazards of falls, poisoning (which includes an appendix of poison information centers), hazards associated with automobiles, electricity and fire, the hazards of suffocation, explosions of one kind and another, dangers of mechanical devices, drowning, outdoor life, toys, babysitters, emergency aid, and a valuable section on doublechecking. Also included is an appendix, including sources of information on safety.

The book is interestingly written, has numerous illustrations that manage to be humorous and frightening at the same time. The reviewer has not previously seen such a book and believes this one might well be instrumental in saving many lives. It is recommended for all doctors, parents, teachers—virtually anyone who associates with children. The book is attractively paper bound.

W. D. SNIVELY, JR., M.D.
Evansville

There's a Word for It

RICHARD J. NOVEROSKE, M.D.
Evansville

Dorsal Vein of the Penis

WE were taught in medical school, and we use almost without exception in medicine the term "dorsal vein of the penis."

But what's so dorsal about it?

I think this term is a misnomer.

In the penises I've seen, this superficial vein is ventral or anterior.

If the penis is erect, this vein could be called the superior vein of the penis.

But the penis usually isn't erect; it's dependent. I think ventral or anterior is a more accurate term for this vein.

I've wondered for some time how this term "dorsal vein of the penis" got started in medicine, and how it got such a habitual grip on our minds.

The only explanation I can suggest is that some anatomist, dissecting on a supine cadaver with the penis retracted superiorly and lying on the lower anterior abdominal wall, saw this vein, lying dorsal in this position, and named it "dorsal vein." Similarly, he named this aspect of the penis, "the dorsum of the penis," and called its arteries and nerves "dorsal arteries" and "dorsal nerves." But these terms don't conform to our idea of the anatomic position, with a man standing upright.

There are two main veins coming from the penis, a superficial one and a deep one, and they could be named "superficial" and "deep" veins of the penis, with our knowing that both lie ventral or anterior in the penis.

If physicians want to forget about the deep penile vein and just concentrate on the prominent superficial vein, I guess it would be all right to call it the "ventral vein of the penis." Even this shortcut would be an improvement over "dorsal vein of the penis."

3901 Lincoln Avenue
EVANSVILLE 47715

Discussion of Essay #1, "Arm-Forearm and Thigh-Leg"

To the editor:

In response to the communication from Richard J. Noveroske, M.D., of Evansville, in the October 1976 issue of *The Journal,* there are several appropriate comments.

1. A very plausible explanation for the problem in conveying to the x-ray department exactly what we want arises from the fact that most of the people actually doing the communicating are not physicians. For example, we might note on our emergency room record sheet what we feel the problem is. Then, we indicate that the appropriate x-ray is to be taken. A paramedical helper, often an aide who has not been trained except for her specific job in a particular institution, reads and interprets our notes, and initiates the proper requisition for the x-ray department, including the clinical indications. At this point in time, the requisition is received, read and interpreted by another relatively untrained person, either an x-ray department secretary, aide or technician who, in spite of his or her expertise in performing x-ray examinations, is still relatively untrained. Using layman's language is not only appropriate but also necessary in these circumstances. The fact that a particular radiologist is unhappy with the way ancillary personnel in his department receive or initiate communications with other paramedical personnel is a rather moot point, for radiologists seldom come into contact with the patients involved, and, except for our more sophisticated procedures, are often not involved in making clinical judgments.

2. Perhaps you were taught in anatomy that extremities were divided into arm, forearm, hand and thigh, leg and feet "regions," but I must confess that I was never taught this terminology. I am a relatively recent graduate of the largest medical school in the United States and I was taught from the first week in class that it is proper to refer to these areas as humeral - radioulnar - carpal - digital and femoral - tibiofibular - tarsal - metatarsophalangeal "regions." I find reference to "humerus" personally preferable to "arm" or "upper arm" and I also find that my specification of the anatomically exact region which I want x-rayed corresponds well with what our technicians in fact

obtain in the x-ray room.

3. In direct answer to Dr. Noveroske's final question, I do feel we have available for us a solution to what is apparently a big problem. It is my feeling that all x-ray requisitions should include a complete listing of procedures and radiographs obtainable in the x-ray department so that the physician can be made to specify exactly what he wants when he orders radiographic procedures.

4. A real aside from this issue, but related because of the overall problem of communication between different sections of the medical discipline, involves the reporting of radiographic studies. In several institutions in which I have practiced, the emergency room physician is the first physician to have close perusal of a radiograph. Clinical decisions will be based upon not a learned radiologist's interpretation in many cases but on the immediate "gut" reaction of the attending physician in the emergency room. We have made it a practice in the institution in which I currently practice to have the attending emergency room physician indicate in his own writing on the top part of the radiological requisition-reporting form his interpretation of the x-ray. At the time when the films are officially read and dictated, the radiologist is inclined, if he feels there is a discrepancy between his interpretation and the attending physician's interpretation, to pick up the phone at that moment and contact the attending physician. Otherwise, it might be a day or days before a copy of the official interpretation reaches the attending staff member.

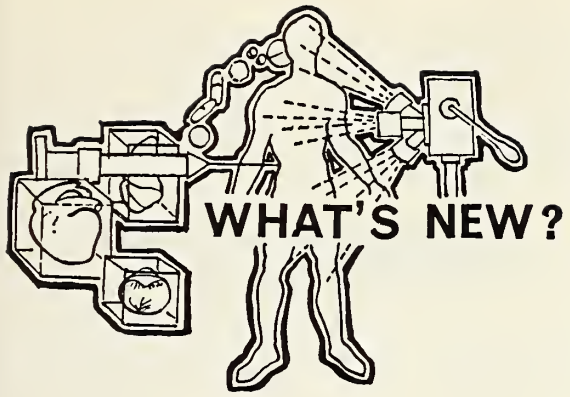
GEORGE W. MERKLE, M.D.
Bluffton

In Brief . . . A Summary of AMA Medical and Health News

The AMA urged a Congressional subcommittee to reopen its hearings on "unnecessary" surgery and "resolve that issue once and for all." In a letter to Rep. John E. Moss (D-Calif.), chairman of the House Subcommittee on Oversight and Investigations, the AMA said it had reexamined the report issued by the subcommittee earlier this year and "we must again conclude that the bases upon which the report's conclusions are predicated are either inaccurate or unsound and, hence, the report's conclusions are invalid." The report was based on a second-opinion study. The AMA said, "We are not opposed to the second consultation concept; but we emphatically do not believe that the result of a second consultation can be taken as the criterion of medical necessity."

HEW informed the AMA that the department is "reexamining its position" on the Uniform Hospital Discharge Abstract, which requires the entry of the names and Social Security numbers of patients and physicians on data sets for the Medicare, Medicaid and PSRO programs. A "notice" of implementation of the UHDA, published by HEW in January, was protested by the AMA on grounds of confidentiality. In a letter to the AMA, the department said "comments from interested individuals and organizations, such as the AMA, have indicated there is a great deal of resistance to the UHDA concept."

Two of last summer's widely publicized charges against the AMA have so far proved groundless. The Postal Service said its investigation, following allegations by an anonymous person who came to be known as "sore throat," shows that the AMA is entitled to use second- and third-class mailing rates. "No further action is required," the Postal Service said. "Sore throat" allegations that the AMA and AMPAC were being investigated by the Federal Elections Commission for election-law violations was scotched by the FEC. There was no investigation. FEC said, "If the facts as alleged were true there would not be a violation of the Federal Election Campaign Act."



Lederle announces a new formulation for triamcinolone acetonide. Quarter Strength Aristocort A Cream with Aquatain™ is recomended for treating large skin areas and for use with occlusive dressings. Lower potency makes it suitable for starter therapy.

* * *

Riker Laboratories has introduced 250 mg Theolair (theophylline) Tablets. This is an increased strength of the single-entity bronchodilator originally marketed early this year by Riker.

* * *

Endo Laboratories announces a new formula narcotic analgesic without salicylates. PERCOCET®-5 contains 5 mg oxycodone hydrochloride (WARNING: May be habit forming) and 325 mg acetaminophen in each tablet. Recomended for aspirin-sensitive patients.

* * *

Doubleday announces a second printing of Frank G. Slaughter's "Plague Ship." The recent mysterious American Legion epidemic in Philadelphia presents the same dilemma as is outlined in the book.

* * *

About Our Cover

A view of the Robertson Chapel, which is in the heart of Butler University's 300-acre campus, graces this month's cover.

The Butler campus is about five miles from the heart of downtown Indianapolis in a scenic residential area in the northwest part of the city.

A coeducational institution founded in 1855, Butler is neither large nor small (2,300 undergraduate students drawn from 40 states and 16 foreign countries). Programs leading toward undergraduate and graduate degrees in five colleges—Liberal Arts and Sciences, Education, Business Administration, Pharmacy and Music, as well as in many pre-professional study areas such as medicine, dentistry, law, medical technology and others —are offered.

Privately endowed, Butler is fully accredited.

Dynatech Cryomedical Company has a new, low cost cryosurgical instrument for use in the doctor's office, clinic or operating room. All operating controls are fitted in a slim, lightweight handle and probe. The streamlined design allows more visibility of the operating field.

* * *

The United Division of Howmedica has a new protective dressing. SKIN-PREP™ Protective Dressing protects sensitive skin when used under ostomy appliances, adhesive bandages and orthopedic plaster casts. SKIN-PREP will allow excoriated skin to heal under its protective coating or will prevent abrasions due to casts and adhesive bandages.

* * *

Bristol is introducting CeeNU™, a new anticancer drug, found to be helpful in primary and secondary brain tumors and in treating Hodgkin's disease. CeeNU, like many chemotherapeutic agents, is toxic to the bone marrow, but the effect is usually delayed by four to six weeks following therapy.

* * *

Pinecliff Publishing has a group of Patient Information Booklets designed to tell patients what they should know about their illness. The booklets average 32 pages and cover such subjects as Cataracts, Gall Bladder Disease, Breast Lump, Prostate Trouble and Back Trouble. Books are edited by Morton K. Rubinstein, M.D., of UCLA Medical Center, Los Angeles. Samples are available.

* * *

News af what is new in the medical supply industry is campased af abstracts fram news releases by manufacturers—af pharmaceuticals, clinical labaratary supplies, instruments and surgical appliances—and baak publishers. Each item is published as news and daes nat necessarily canstitute an endarsement af a praduct or recammendatian far its use by THE JOURNAL ar by the Indiana State Medical Assaciation.





From The Auxiliary

Holiday Time is A Time for Looking up

A Time for Looking Back

A Time for Reaching Out

With Love and Appreciation

for the gifts of talent, interest, time, commitment and donations of our MEMBERSHIP.

At this Joyous Season . . .

Find someone who needs a cheery word—and give it.

Remember someone who has been forgotten by others—give them your attention.

Give someone the excitement of finding something in his mail box.

Share with a neighbor and thus give yourself the warm contentment that it always brings.

May the gifts of joy, peace and love be yours.

Chloe A. Goldsmith

Chloe (Mrs. David A.) Goldsmith
President, ISMA Auxiliary

THE WINNERS—127th Annual Convention Indianapolis, Oct. 9-12, 1976

PHYSICIANS COMMUNITY SERVICE AWARD

This award, through the courtesy of the A. H. Robins Pharmaceutical Company, goes to an Indiana physician for "service to the local or state community which benefits them in a civic, cultural or general economic sense, and is entirely separate from purely professional achievement."

Dr. Max S. Norris, Indianapolis, was cited for his work with Boy Scouts, Masonry, Kiwanis Club, Butler University, the Holcomb Research Institute and the Indianapolis Bicentennial Committee.

SCIENTIFIC EXHIBIT AWARD WINNERS

Awards for the excellence of the scientific exhibits at the 127th Annual Meeting were made to:

First Place: G. Paul DeRosa, M.D., Merrill A. Ritter, M.D., and Craig G. Gosling, Indianapolis—Simulators to Enhance Psychomotor Skills.

Second Place: Jerry L. Kight, M.D., Indianapolis—Radionuclide Evaluation of Acute Intrascrotal Swelling.

Third Place: Nancy A. Roeske, M.D., Indianapolis—From Thought to Action—An Example of Curriculum Design and Implementation.

JOURNALISM AWARDS

At the President's Dinner on Oct. 11 the annual journalism awards were presented to the following:

Television—Bill Wilson, reporter for WRTV-6, Indianapolis, for "the outstanding job he did in researching and communicating—accurately and fairly—all aspects of the medical liability crisis in Indiana."

Radio—Indianapolis station WTLC-FM, for "its all-out public service campaign concerning the need for immunizing school age children."

Newspapers—Jerry Gengler, city editor of the Gary Post-Tribune, for his five-part series on the latest findings in a wide range of cancer research projects.

GOLF TOURNEY WINNERS

Men

Gross—Boyd Burkhardt, Tipton; Meredith Gossard, Tipton; Robert Stone, Ligonier. **Net**—John Records, Franklin; Irvin Zeiger, South Bend; Donald Chamberlain, South Bend. The "tail ender" award went to Dr. Ray Burnikel, Evansville.

Women

Gross—Lois Sheehan; Dottie White; Mary Kennedy. **Net**—Mary Hull, Mrs. John Records, Mrs. R. Yingling.

TENNIS TOURNEY WINNERS

Men

Singles—Dan Shull, Indianapolis, Lloyd Gammell, Columbus.

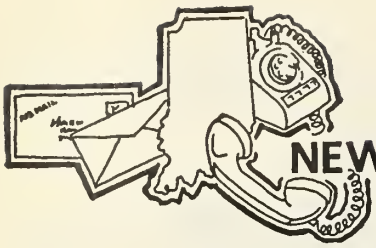
Doubles—Richard Powell and Bill Dick, Indianapolis; Bryant Bloss, Evansville, and Jerry Frankel, Indianapolis.

Women

Singles—Kay Clark, Avon; Kitty Buckel, Carmel.

Doubles—Nalda Powell, Indianapolis, and Kitty Buckel, Carmel; Kay Clark, Avon, and Billie Wheeler, Terre Haute.





Searle Announces Third Module In Master Lecture Series

Searle Laboratories announces the third module in the Searle Master Lecture Series "Management of Cardiac Failure." The module is flexible and includes an audio cassette, 35mm slides, a monograph and a special monograph insert with the slides reproduced in color. The tape may be played while the slides are projected, the monograph may be used as a lecture outline, the slides can illustrate your own presentation. For smaller groups the tape may be played while each listener views the slides reproduced in his own copy of the monograph insert. The program is suitable for medical students, interns, residents, general nursing staff and pharmacists, and especially for those working in ICU or CCU.

Write Searle at 4901 Searle Parkway, Skokie, Ill. 60076 giving date preferred, alternate dates and estimated number of persons attending.

Continuing Medical Education

The following Indiana physicians are recent winners of the coveted AMA Physician's Recognition Award:

Fred Adler, Munster
Frank A. Benchik, East Chicago
James E. Bolander, Fort Wayne
Edward A. Campagna, East Chicago
Gregorio H. Dimailig, East Chicago
Luis N. Galup, South Bend
Stephen D. Hathway, South Bend
John O. Hildebrand, South Bend
Anabel Ratcliff Jones, Lafayette
Chang Young Kim, Terre Haute
Robert R. Nelson, South Bend
Brian S. Potter, Michigan City
Richard E. Riehl, Jeffersonville
Richard J. Shelley, Indianapolis
Jerald E. Smith, Munster
Jack M. Troy, Hammond
C. Kenneth Wilhelmus, Evansville

DES Exposure Warning Given; Booklets Available

The consequences of exposure of a female fetus to diethylstilbestrol (DES) during the first 18 weeks of pregnancy may be serious. Some one million girls born in the 1940s and 1950s should be examined for clear cell adenocarcinoma of the vagina or cervix and for benign adenosis of the vagina. All girls born of mothers between 1940 and 1960 for which the records indicate exposure to DES should be examined and followed and, since it may be difficult to determine whether the mothers of some girls were treated with DES, it is recommended that all girls of this era be checked.

The Office of Cancer Communications, Department IN, Bldg. 31, Room 10A19, National Cancer Institute, NIH, Bethesda, Md. 20014, will send, on request, free copies of (1) Information for Physicians—DES Exposure in Utero; (2) Information for the Concerned Public—Questions and Answers about DES Exposure Before Birth; and (3) Information for the General Public—Were You or Your Daughter Born After 1940?

Hoosiers Attain CMA Certification

A record number of applicants passed the certification examinations of the American Association of Medical Assistants. The tests were conducted in Chicago in September. One thousand eight hundred fifteen certificates, including 101 for members from Indiana, were granted. The successful candidates are entitled to use the initials CMA (Certified Medical Assistant) after their names.

Cancer Institute Appoints Dr. Pollard

Dr. Morris Pollard, director of the Lobund Laboratory of the University of Notre Dame, has been appointed chairman of the National Cancer Institute's new committee on Tumor Immunology for Applications to Cancer Cause and Prevention. Dr. Pollard has also been appointed to the U.S. Breast Cancer Task Force of the National Cancer Institute.

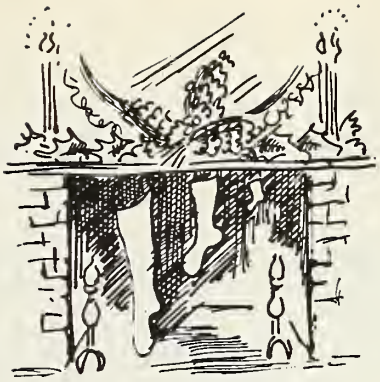
Medical Assistants Honor Dr. Thomas

Dr. Lowell Thomas, Indianapolis, who has served for many years as advisor and chairman of the Physician-Advisory Board of the American Association of Medical Assistants, was awarded Honorary Membership in the Association, at its 20th Anniversary Convention in Chicago this fall.

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Schedule for Upcoming NCME Programs

The Network for Continuing Medicol Educotion Announces the following schedule of progroms:

Dec. 13-26 CARDIAC REHABILITATION: A STATUS REPORT, with Elliott M. Stein, M.D., assistant professor of medicine, New Jersey College of Medicine ond Dentistry, ond chief of the Exercise Loborotory ond the Cordio: Rehobilitotion Progrom, Saint Michael's Medicol Center, Nework, N.J.

EXTRA-ARTICULAR MANIFESTATIONS OF RHEUMATOID ARTHRITIS: KEEP A HIGH INDEX OF SUSPICION, with Rodney Bluestone, M.B., M.R.C.P., chief, Rheumotology Section, Wodsworth VA Hospitol, Los Angeles; ond Professor of Medicine, UCLA School of Medicine, Los Angeles.

HOW TO ASSESS THE WHIPLASH INJURY, with John E. Stewort, M.D., clinicol professor of orthopedic surgery, University of Woshington School of Medicine, Seottle.

Dec. 27-Jon. 9 HYPERURICEMIA, GOUT AND PSEUDO-GOUT: WHERE ERRORS OCCUR, with Rodney Bluestone, M.B., M.R.C.P., Chief, Rheumotology Section, Wodsworth VA Hospitol, Los Angeles; ond Professor of Medicine, UCLA School of Medicine, Los Angeles.

EARLY ASSESSMENT AND TREATMENT OF CLUB FOOT, with Rosamond Kone, M.D., Director of Child Foot Clinic, Columbio Presbyterion Medicol Center, New York City.

Jon. 10-23 VIRAL INFLUENZA: FROM ONSET TO AFTERMATH, with Horry M. Rose, M.D., practicing internist with Sondwich Heolth Associotion, member of Infectious Diseose Committee of the Notionol Institute for Allergy ond Infectious Disease, ond consultont in medicine ot Columbio Presbyterion Medical Center, New York City.

ISONIAZID, THE LIVER AND THE TUBERCLE BACILLUS, with Williom W. Steod, M.D., professor of medicine, University of Arkonsos School of Medicine ond director of tuberculosis progrom for the Arkonsos Stote Deportment of Heolth, Little Rock.

COMMON FOOT PROBLEMS IN EARLY CHILDHOOD, with Rosomond Kane, M.D., director of Child Foot Clinic, Columbia Presbyterion Medicol Center, New York City.

Jon. 24-Feb. 6 TOXEMIA AND HYPERTENSION IN PREGNANCY, with Thomos F. Ferris, M.D., professor of medicine, ond director, Division of Renol Diseose, Ohio Stote University School of Medicine, Columbus, O.

THE MANAGEMENT OF CARDIAC ARRHYTHMIAS, with Edmund H. Sonnenblick, M.D., professor of medicine, chief, Cordiology Division; ond Williom H. Frishmon, M.D., director, Non-Invosive Cordiology, both ore of Albert Einstein College of Medicine, New York.

For more informotion obout NCME, write The Network for Continuing Medical Educotion, 15 Columbus Circle, New York, N.Y. 10023.

Pamphlet on Holiday Safety Offered

The National Fire Protection Association has available for sale small flyers on the subject "A Fire Safe Holiday." These are priced at $1.75 per hundred. They are designed for enclosure in mailings on other subjects and are suitable for physicians to distribute with statements. The object is to remind patients that there are special hazards of fire during the holidays. Preventive advice is included. The address is 470 Atlantic Ave., Boston, MA 02210.

Essay Contest Announced by AAPS

The Indiana Chapter of the Association of American Physicians and Surgeons is sponsoring the AAPS Free Enterprise Essay Contest. It is open to secondary school students, grades 7-12. Physicians' children are not eligible. The Association is making source materials and reference material available for all interested schools and will award prizes in both county and state contests.

4th Edition of Current Procedural Terminology Available by Year-End

The 4th edition of the AMA's *Current Procedural Terminology* is scheduled for publication by the end of the year. Companion computer tapes for the new edition will be available for use in billing and insurance reporting. The 3rd edition of CPT was published in 1973. The 4th edition will contain many new procedures.



HANGER PROSTHESES OFFERS BOOKLET ON AMPUTATIONS

This booklet hos been designed for those physicions whose proctice includes omputotion. Limb Prosthetics gives reody reference for eoch site of omputotion os well os the prostheses recommended for eoch site.

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We believe thot you will find Limb Prosthetics o most useful booklet ond o voluable source of quick informotion. To obtoin your copy, pleose write or phone the Honger office neorest you.

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3004 S. Wayne Ave., Fort Wayne, Ind. 46807

Deaths

Thomas C. Haller, M.D.

Dr. Thomas Ctibor Haller, 69, Crawfordsville surgeon, died at his home Sept. 24. He retired in March 1974.

Dr. Haller earned his M.D. degree at Northwestern University in 1932 and interned at Los Angeles County General Hospital. He received his surgical training at the Barnes Hospital and Washington University Medical School, St. Louis, after which he served for six years as medical director of clinics at the Chicago Medical School. He also held a staff appointment with Lutheran Deaconess Hospital, Chicago.

From 1942 until 1946 Dr. Haller was medical director for Community Hospital at Williamsport.

Dr. Haller was a Fellow of the American College of Surgeons, International College of Surgeons, the American College of Gastroenterology and the American Society of Abdominal Surgeons.

A member of the Montgomery County Medical Society, Dr. Haller was also a member of the American Medical Association. He had been a founder member of the Royal Society of Medicine (London) and Collegium Internationale Chirurgiae Digestivae (Rome).

George E. Moses, M.D.

Dr. George Elmo Moses, 79, Worthington, died Sept. 15 in Greene County General Hospital, Linton.

Dr. Moses graduated from the Indiana University School of Medicine in 1930 and practiced general medicine at Worthington from that time on.

During World War I he served in the U. S. Army.

Dr. Moses was a past president of the Greene County Medical Society and served as chief of staff at the Greene County General Hospital until forced by illness to retire. A member of the American Medical Association, Dr. Moses was a senior member of the Indiana State Medical Association.

Byron Nixon, M.D.

Dr. Byron Nixon, 79, died at Ball Hospital, Muncie, Sept. 23. He practiced at Farmland until his retirement in 1966.

A graduate of Rush Medical College with the class of 1922, Dr. Nixon also trained in Vienna and had been licensed to practice medicine in Wisconsin, Illinois and Texas, as well as in Indiana. His internship was served at Presbyterian Hospital, Chicago.

Dr. Nixon was a Fellow of the American College of Surgeons. He was also a member of the Randolph County Medical Society and the American Medical Association and was a senior member of the Indiana State Medical Association. In 1972 he became a member of the 50-Year Club.

Robert E. Sabina, M.D.

Dr. Robert E. Sabina, Munster, drowned in the swimming pool at his home Aug. 31. Forty-two years of age, he had been in practice at the Hammond Clinic as a nephrologist since 1968.

A 1962 graduate of the University of Chicago School of Medicine, he interned at Presbyterian-St. Luke hospitals in Chicago and served residencies at the University of Chicago and the University of Washington, Seattle.

For the two years he was in the U. S. Army he was stationed at Madigan General Hospital, Tacoma, and with the 36th Evacuation Hospital in Viet Nam.

Dr. Sabina was a member of the Lake County Medical Society and the American Medical Association.

Leslie E. Werry, M.D.

Dr. Leslie Edward Werry, a Blackford County physician since 1919, died at the Blackford County Hospital September 25. He was 92 and retired from active practice in 1962.

Dr. Werry was a 1913 graduate of the University of Louisville Medical School and interned at the U.S. Marine Hospital, Evansville.

During World War I Dr. Werry served with the Medical Corps, following which he began his practice of general medicine in Hartford City.

A senior member of the Indiana State Medical Association, Dr. Werry became a member of the 50-Year Club in 1963. He was also a member of the Delaware-Blackford County Society and the American Medical Association.



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The 1976 Convention Story



EIGHT HUNDRED YEARS of medical practice was represented at the reception for 50-Year Club members preceding the President's Dinner.





THE PRACTICE Management Program presented by Clayton L. Scroggins Associates on Sunday morning (above and right) was well attended.



THE 1976 HOUSE OF DELEGATES IN SESSION



THE EXECUTIVE Committee convened at 10 o'clock Sunday morning.



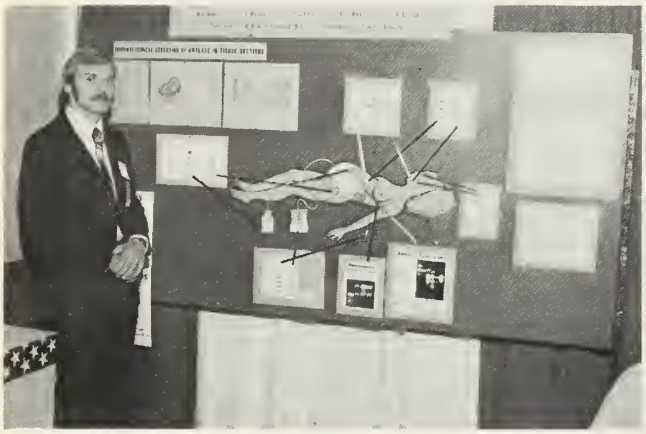
A LUNCHEON meeting at 12 noon on Sunday was the first business meeting slated for the Board of Trustees.

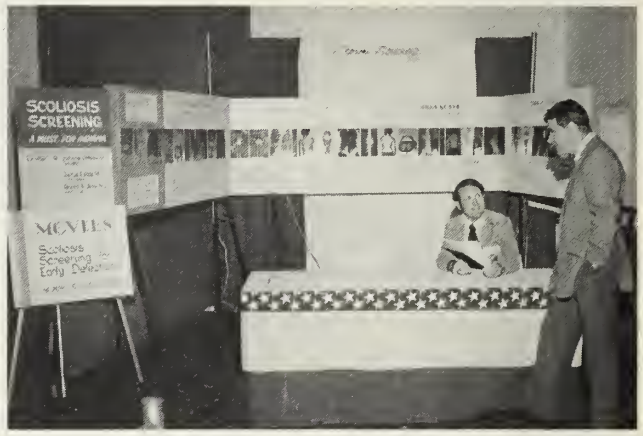


AT THE HEAD table at the IMPAC Luncheon were (left to right) Dr. Fred Smith, Tell City, chairman; Senator Robert Packwood (R-Ore.), speaker; Governor Otis Bowen, M.D., and Mrs. Bowen.



PAST PRESIDENTS in attendance at their annual luncheon were (seated, left to right): Drs. Gilbert Wilhelmus, Peter Petrich, James Gosman, Patrick Corcoran and Joe Black, standing, Drs. Eugene Rifner, Lowell Steen and Guy Owsley.





Two of this year's interesting Scientific Exhibits.

ON HAND for the Editorial Board luncheon when the photographer arrived were: (seated) Dr. Wei-PingLoh, Dr. Ramsey, Mrs. Jean Richardson, Dr. Steven C. Beering; (standing) Dr. Irvin Wilkins, Dr. Rodney Mannion, Mr. Donald F. Foy.



Presentation of the Sandoz Journalism Award for "Excellence in Design and Editorial Content" was made at the first session of the House of Delegates to Dr. Frank B. Ramsey, editor of The Journal, by Mr. Paul C. Kelley, regional manager for Sandoz Pharmaceuticals.







Meetings!





Meetings!





Meetings!









Reference Committees at Work









THE ANNUAL DINNER of the Association of American Physicians and Surgeons was held Sunday evening.



INCOMING PRESIDENT John W. Beeler presents the Past President's Plaque to Dr. Vincent J. Santare (below, left).

PRESIDENT SANTARE presents the newspaper award to Jerry Gengler, city editor of the Gary Post-Tribune.





A VIEW of the crowd in attendance at the President's Dinner, with the head table in the background. Dancing followed the formal program.



Convention Election Results

Dr. Eli Goodman Named President-Elect

Dr. Eli Goodman, Charlestown, was elected president-elect of the Indiana State Medical Association at the closing session of the House of Delegates in October. He succeeds Dr. John W. Beeler, Indianapolis, who was installed as president on Oct. 12.

(An account of the career and service to organized medicine of Dr. Goodman appeared in the November *Journal.*)

Dr. Arvine Popplewell, Indianapolis, and Dr. Joseph F. Ferrara, Franklin, were reelected treasurer and assistant treasurer, respectively.

Dr. James A. Harshman, Kokomo, was elected chairman of the Board of Trustees, while Dr. Joe Dukes, Dugger, was reelected chairman of the Executive Committee.

Dr. Richard G. Ingram, Montpelier, was reelected to the committee, and Dr. Vincent J. Santare, immediate past president, will also serve on the committee.

Dr. Lloyd L. Hill, Peru, who has served as vice-speaker of the House of Delegates for the past year, succeeds Dr. William R. Cast, Fort Wayne, as speaker. The new vice-speaker is Dr. Lawrence E. Allen, Anderson.

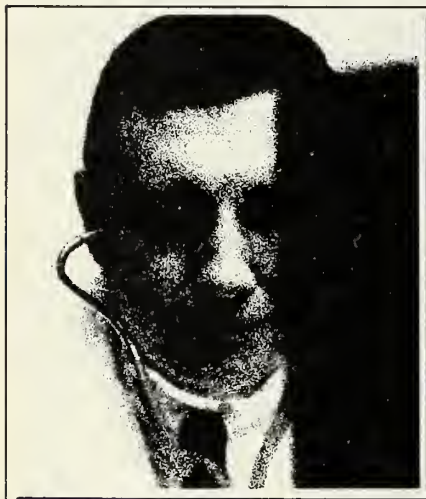
New trustees chosen for three-year terms by their districts are Dr. Thomas Neathamer, Jeffersonville, District 3; Dr. Glen Ward Lee, Richmond, District 6; Dr. John A. Knote, Lafayette, District 9; all had been serving as alternate trustee.

Dr. Alvin J. Haley, Fort Wayne, was reelected to a three-year term as trustee.

Newly elected alternate trustees are Dr. Richard G. Huber, Bedford, District 3; Dr. Mark M. Bevers, Seymour, District 4; Dr. Davis W. Ellis, Rushville, District 6; Dr. Ted S. Doles, Middletown, District 8.

Drs. E. DeVerre Gourieux, Evansville, William G. Bannon, Terre Haute, and Donald S. Chamberlain, South Bend, were reelected to three-year terms as alternate trustees, representing districts 1, 5 and 13.

Dr. Ross L. Egger, Daleville, was chosen as a new delegate to the American Medical Association, succeeding Dr. John O. Butler, Indianapolis. Dr. Gilbert M. Wilhelmus, Evansville, succeeds Dr. Egger as alternate AMA delegate. Their terms will expire Dec. 31, 1978.



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1976

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House of Delegates Proceedings

October 10 and 12, 1976
INDIANAPOLIS SESSION

The first meeting of the House of Delegates convened at 3 p.m., Sun., Oct. 10, 1976, in the Ballroom Centre of the Indianapolis Hilton, with Dr. William R. Cast, speaker of the House of Delegates, presiding and assisted by Dr. Lloyd L. Hill, vice speaker.

The final meeting of the House was convened at 1:30 p.m., Tues., Oct. 12, 1976, in the Ballroom Centre of the Indianapolis Hilton.

Invocation was given by Dr. Malcolm O. Scamahorn, Pittsboro.

Dr. Lester Hoyt, Indianapolis, served as parliamentarian.

In Memoriam

Following is a list of members of the Indiana State Medical Association who were members of the House of Delegates or who served the Association in an official capacity and who have died since the 1975 annual session.

AVEY M. BAKER, New Albany
RAYMOND C. BEELER, Indianapolis
GAH T. BOWERS, Fort Wayne
ARNOLD W. BROCKMOLE, Evansville
SAM W. CAMPBELL, New Castle
IRA COLE, Lafayette
KENNETH E. COMER, Morresville
JOHN D. COONS, Lebanon
SETH E. ELLIS, Anderson
HERMAN S. HEPNER, Bloomington
MARION HOCHHALTER, Logansport
IRVIN E. HUCKLEBERRY, Salem
VERLIN P. HUFFMAN, South Whitley
CHARLES A. JONES, Franklin
RUSSELL W. LAVENGOOD, Marion
RALPH E. McINDOO, Kokomo
RICHARD G. MEHNE, Brazil
GEORGE W. RITTEMAN, Franklin
JAMES B. ROSS, Bloomington
NATHAN L. SALON, Fort Wayne
HARVEY K. STORK, Huntingburg
ALBERT E. STOUDER, Kempton
JOHN V. THOMPSON, Indianapolis
FRED L. TOUMEY, Indianapolis
HAROLD B. TURNER, Bloomfield
MALCOLM L. WREGE, Indianapolis

Report of Credentials Committee

Dr. Robert M. Brown, chairman of the Credentials Committee, reported at the first meeting the attendance of 95 delegates, 13 trustees, and 11 past presidents. Attendance at the final meeting was 123 delegates, 14 trustees, and 13 past presidents. A quorum is 50.

Approval of Minutes

The proceedings of the 126th annual meeting of the House of Delegates held in French Lick, Ind., and published in the December 1975 *Journal of the Indiana State Medical Association* were approved.

Introduction of Guests

The speaker introduced Dr. Joseph Smith, president-elect, West Virginia State Medical Association; Dr. Frank Jirka, AMA trustee and director of the AMA Education and Research Foundation; Dr. James F. Bishop, president, Iowa Medical Society and Dr. Robert M. Leitch, president, Michigan State Medical Society.

Journal Award

Mr. Paul C. Kelley, regional manager of Sandoz Pharmaceuticals, presented to Dr. Frank B. Ramsey, editor, the first place award in the 1975 Sandoz Journalism Competition for state medical journals with a circulation of more than 3,000. The award consisted of a check for $500 and a plaque stating that the award was made to *The Journal of the Indiana State Medical Association* for "excellence in design and editorial content."

Address of the President
Vincent J. Santare, M.D.

ACTION: Referred to the Commission on Medical Education for the development of a voluntary statewide coordinated medical education program for the state of Indiana.

President-Elect Beeler, Distinguished Guests, Visitors, and fellow physicians:

I have been extremely proud and appreciative of the activities of the Indiana State Medical Association in the past year. This began with the realization that we must replace an Executive Director who is recognized as one of, if not the most capable state medical association directors in the country. The intense and concentrated effort expended by our search and screen committee, consisting of Drs. Wilhelmus, Wood, Corcoran, Ingram, Beeler, Goodman and myself was amply rewarded with the discovery of Mr. Don Foy, who was eventually selected by the Board of Trustees.

This able and extremely competent successor to Mr. Waggener has amply allayed any fears of a violent changeover in our medical association during the transition. Mr. Foy's infusion of a fresh and vigorous outlook and new energy can only result in a better and stronger association.

This present 127th meeting of the House of Delegates and its Convention is the product of many minds spending long hours in response to the recommendation of the 1975 House of Delegates, which recommended beginning the Convention on Sunday afternoon and completing it on Tuesday. The intention of the House seemed to direct a short, concentrated Convention which would not take up too much time of our busy Delegates. However, it was to be sufficiently stimulating as to continue the active participation of our members. The Commission on Convention Arrangements, chaired by Dr. John Ferry, deserves recognition for its courage and deliberation in innovating a convention which meets the organizational needs of the ISMA, yet has a scientific component which is not only attractive but has been accredited for Continuing Medical Education.

The decrease in number of Commissions and Committees, as provided for in our constitutional change last year, has resulted in an increased member participation and increased production in the function of these commissions. The Commission on Legislation has been particularly noteworthy in reviewing health legislation. One example is its support of the Governor's veto of S.B. 111. This bill would permit the licensing of physicians in Indiana on the condition that the applicant had passed the ECFMG examination. The ECFMG examinations are given and corrected all over the world. It would be possible to have exposed the people of Indiana to 20,000 newly licensed physicians last year; none of whom would have been tested for professional competence adequately. The upholding of the Governor's veto by the Senate can be believed to have been strongly influenced by the testimony of the members of this Commission.

The passage of House Bill 1310 allowed desirable amendments to Public Law 146, the Indiana Malpractice Law, without essential change and permitting time to test its efficacy. There are many other examples of the action of this particular commission, and I do wish to mention that they are continuing to meet, in order to prepare for legislative activity in the next legislature and not awaiting the reorganization of the commission.

The Constitution and Bylaws are of-

fering a new look. Formerly, changes in our Constitution were duplicated in sections of the Bylaws. This resulted in confusion when the Bylaws were changed, for a portion of the Constitution dealing with the same subject required another year and another exposure to the House of Delegates for approval. This was nonproductive and confusing, inasmuch as the change was anticipated but could not be implemented until the final changes in the Constitution. Our Constitution will be streamlined so that the fundamental safeguards of our Constitution will remain in the Constitution, and those elements which ought to be changed according to time and situation and other circumstances, will be in the Bylaws and will be amended as provided for in our present Constitution.

Public Information continues its services with booklets to new members, changes in the Medicare leaflet, and a Speakers Bureau. I would hope that our Speakers Bureau would undertake the task of aggressively presenting our aspect to the public. At the present time, when the medical care is such a well-discussed topic and usually attributed to inflation, let our Speakers Bureau indicate that the increased cost of medical care is not merely due to inflation but due to the cost of additional services. Trauma centers, burn centers, CCUs, ICUs, cardiac monitoring for surgery, better pulmonary therapy, expensive diagnostic methods —such as echograms, mammograms, angiography, radioisotopic scanning and, finally, computerized scanning—are not without expense. These permit a greater accuracy of diagnosis and a better method of treatment but add further expense to medical care. We must make a judgment as to whether we wish to continue our progress in medical care with its increased cost or to attempt a false economy by reducing the cost of medical care and hindering further progress.

The Commission on Medical Services is represented for its efforts by three resolutions which have been introduced concerning Medicaid and the aging. In addition, its Public Health Subcommission has investigated the potential Swine Flu epidemic and has come out with recommendations which have been distributed to the membership and I shall not repeat them at this particular time. The Medical Services Commission has been interested in CHAMPUS, and until new federal regulations mandated change, was very causative in having CHAMPUS patients paid at a rate based on the California Relative Value Scale, rather than a Medicare rate.

The program of Sports and Medicine, which was inaugurated last year, is being continued and will be followed next year in the appropriate subcommission of the Commission on Medical Services.

The Commission on Medical Education, through its Subcommission on Medical Accreditation, has accredited more than 30 of the 50 hospitals of 100 beds or more in the state of Indiana. It has begun a program of accreditation in the small hospitals. It is being extremely careful to see that only proper programs are accredited, and not merely the accreditation of all applicants, in order to please those requesting such approval. In the aspect of demands by the government or consumer groups for relicensure, a suggestion by this Commission has been for Continuing Medical Education to be a requisite for membership in the Indiana State Medical Association. Continuing Medical Education, in the fashion of the Physician's Recognition Award, is already mandated by the Academy of Family Practice. It will be a requirement of all the specialty boards and is being implemented in the specialty societies. At one time I thought that Continuing Medical Education, on a trial basis, should be made a requirement for an elite state medical association. However, on careful consideration of the amount of effort, cost and involvement in such a program, I cannot feel that the value is worth the expenditure. Most doctors will continue postgraduate training in education without the goal of relicensure or requirement for state medical association membership. Inasmuch as other organizations are now requiring continuing medical education, perhaps it would be superfluous for us to do so in our state medical organization.

There are two general points that I would like to bring up in my final address to this association as its president. First, the fallacy of the shortage of doctors; we have added 29 new medical schools and 12 more are in the planning stage in the past 10 years. We have increased the number of medical graduates 17% in the last 5 years. Our projection is that by 1985 we will have increased the number of doctors by 70%. We will be graduating about 16,000 physicians from American medical schools and accepting about 5,000 foreign medical graduates. The doctor-population ratio, which at the present time is about 169 physicians per hundred thousand population, will be increased to well over 200 doctors per hundred thousand population. If this increase in physicians results in more primary practitioners, we can see that the need for physician assistants and nurse practitioners is going to be greatly diminished and, perhaps, non-existent. Therefore, I urge that we do not engage in a program of increasing paramedical personnel with a short-range viewpoint.

On January 1, 1975, President Ford signed into law 93-641, the Health Planning Act. This Act requires that the planning agencies should be a majority of consumers. Perhaps in an attempt to preserve some sanity in the bill there is a section which requires that 30% of the planners should be primary providers of health care. Unfortunately, in the makeup of the health service agencies in Indiana and other states, the planners have seen fit to reduce the number of physicians in the executive committees and boards of directors of the health planning agencies. This is shortsighted, inasmuch as the physician is most competent and least biased to do proper planning for health. The physician has been, in the past, the individual to whom the public has come for authoritative and serious and unbiased advice concerning his health problems. Unfortunately, the newer aspect seems to feel that the physician is either incompetent or too biased or too indifferent to health planning and places this important aspect within the hands of consumers. The consumers are guided, in most cases, by a very young, inexperienced staff, who despite their enthusiasm, are in most cases not adequately or properly directed. Their education in health planning is usually given by people who are educated in other disciplines. I believe that we should participate in health planning. I believe that we should have some method of communication concerning health planning and participation by physicians where approving a grant will not mean that if we don't accept it we will lose the federal money but rather that this grant is necessary for improving the health of our people.

Remarks of Speaker William R. Cast, M.D.

The speaker's job is relatively new, being only three years old. The position places one in a position to see and work with delegates—many of whom are not seen other than at the October meeting. As it is necessary to continue to infuse new talent into the working organization of doctors, it may be of benefit to ISMA for the speaker to act to recruit new talent to work on a more regular basis and to aid the president and the Board of Trustees in this effort. A job description might be described as including recruitment and training in procedure, public relations and any other task requested by the president or the Board.

The speaker announces his non-candidacy and gratitude for being allowed to serve.

Any delegate may introduce a resolution from the floor provided that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reason why said resolution was not mailed to the Executive Secretary more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reason why said resolution is of such an emergency nature that it cannot wait until the next meeting

of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the Bylaws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Committee on Rules and Order of Business is in session in the rear of the Convention Hall.

Appointment of Reference Committees

In accordance with the Bylaws, I have appointed reference committees, and the names of the members of these committees are published in the Handbook.

These reference committees are to serve during this annual convention only.

To these reference committees will be referred all reports, resolutions and measures presented to the House of Delegates at this session, except such matters as properly come before the Board, and the recommendations of these committees shall be submitted at the final meeting of the House of Delegates at 1:30 p.m., EST, Tues., Oct. 12, for acceptance in the original or modified form, or for rejection.

Each reference committee consists of at least five members; the first member named is chairman. Will committee members please stand as their names are called?

REFERENCE COMMITTEE NO. 1

Nicholas L. Polite, Whiting, *chairman* (Lake County)
Kenneth J. Ahler, Rensselaer (Jasper County)
Richard L. Glendening, Logansport (Cass County)
James A. Marvel, Evansville (Vanderburgh County)
Lee F. Dupler, Frankfort (Clinton County)

REFERENCE COMMITTEE NO. 2

John A. Knote, Lafayette, *chairman* (Tippecanoe County)
Herbert C. Khalouf, Marion (Grant County)
Glen Ward Lee, Richmond (Wayne-Union County)
Alfred C. Cox, South Bend (St. Joseph County)
Max N. Hoffman, Covington (Fountain-Warren County)

REFERENCE COMMITTEE NO. 3

Fred W. Dahling, New Haven, *chairman* (Allen County)
Thomas A. Neathamer, Jeffersonville (Clark County)
Forrest E. Radcliff, Evansville (Vanderburgh County)
George M. Haley, South Bend (St. Joseph County)
Everett E. Bickers, Floyds Knobs (Floyd County)

REFERENCE COMMITTEE NO. 4

George T. Lukemeyer, Indianapolis, *chairman* (Marion County)
Warren L. Bergwall, Muncie (Delaware-Blackford County)
Thomas J. Conway, Terre Haute (Vigo County)
George M. Underwood, Lafayette (Tippecanoe County)
Thomas A. Gehring, Merrillville (Lake County)

REFERENCE COMMITTEE NO. 5

Donald S. Chamberlain, South Bend, *chairman* (St. Joseph County)
R. Wyatt Weaver, Angola (Steuben County)
E. Henry Lampkin, Indianapolis (Marion County)
William F. Blaisdell, Seymour (Jackson County)
Marvin L. McClain, Scottsburg (Scott County)

REFERENCE COMMITTEE ON RULES AND ORDER OF BUSINESS

George T. Lukemeyer, Indianapolis *chairman*
Nicholas L. Polite, Whiting
John A. Knote, Lafayette
Fred W. Dahling, New Haven
Donald S. Chamberlain, South Bend

CREDENTIALS COMMITTEE

Robert M. Brown, Marion, *chairman*
Walfred A. Nelson, Gary
Merrill M. Wesemann, Franklin

TELLERS

Peter E. Gutierrez, Crown Point
Loren Martin, Indianapolis
T. Neal Petry, Delphi
Peter J. Pilecki, Michigan City

Election of AMA Delegates and Alternate Delegates

The following were elected to a two-year term as delegate and alternate delegate to the American Medical Association, their terms to expire Dec. 31, 1978:

Delegate, James A. Harshman, Kokomo; alternate, George T. Lukemeyer, Indianapolis; delegate, Ross L. Egger, Daleville; alternate, Gilbert M. Wilhelmus, Evansville; delegate, Malcolm O. Scamahorn, Pittsboro; alternate, Everett Bickers, Floyds Knobs.

Election of Officers

Dr. John Beeler of Indianapolis assumed the office of president and Dr. Eli Goodman of Charlestown was elected president-elect.

Dr. Arvine G. Popplewell, Indianapolis, was reelected treasurer.

Dr. Joseph F. Ferrara, Franklin, was reelected assistant treasurer.

Dr. James A. Harshman, Kokomo, was elected chairman of the Board of Trustees. Dr. Joe Dukes of Dugger was elected chairman of the Executive Committee.

Dr. Lloyd L. Hill of Peru was elected speaker of the House of Delegates and Dr. Lawrence E. Allen of Anderson was elected vice speaker of the House of Delegates.

Election of Trustees

Dr. Thomas A. Neathamer, Jeffersonville, was elected trustee of the Third District; Dr. Glen Ward Lee, Richmond, was elected trustee of the Sixth District; Dr. John A. Knote was elected trustee of the Ninth District; Dr. Alvin J. Haley was reelected trustee of the Twelfth District.

Dr. E. DeVerre Gourieux, Evansville, was reelected alternate trustee to the First District; Dr. Richard Huber, Bedford, was elected alternate trustee to the Third Distict (unexpired term); Dr. Mark M. Bevers, Seymour, was elected alternate trustee to the Fourth District; Dr. William Bannon, Terre Haute, was reelected alternate trustee to the Fifth District; Dr. Davis W. Ellis, Rushville, was elected alternate trustee of the Sixth District; Dr. Ted S. Doles, Middletown, was elected alternate trustee of the Eighth District; and Dr. Donald Chamberlain was reelected alternate trustee of the Thirteenth District.

Address of President-Elect John W. Beeler, M.D.

ACTION: Referred to the board of trustees.

I would like to present to you, as members of the House of Delegates and the policy-makers of this Association, several issues which are of primary concern to me personally. I hope these will be equally important to you.

Gib Wilhelmus singlemindedly and successfully fought the battle of malpractice legislation. Vince Santare has successfully reorganized the commission system and presided over the smooth transition of our Executive Staff.

ISSUES:

1. **Arbitration**
 Not a union—time has come to *consider* arbitrating reasonable reimbursement for our medical services.
 Blue Shield—if national union contracts negotiated outside Indiana and offered by insurance carriers in this state (i.e., Blue Shield) are unpalatable to our membership, we would have the right and the obligation to arbitrate satisfactory reimbursement for our services.

2. **Corporate Practice of Medicine**
Only 68% in private practice.
E.R. (Charlestown) — Methodist, Evansville.
The mode by which we practice is changing as rapidly as the scientific aspects of medicine. The corporate practice of medicine provides one of the potentials for jeopardizing the quality of our patients' medical and health care.

3. **Cost of Health and Medical Care**
One third of all outpatient physician visits are unnecessary.
Defensive medicine—skull x-rays in E.R.
Malpractice problem still not solved.
As physicians, we are the one group with which every patient who seeks medical and health care must come in contact. If for no other reason, we then become a target in discussions of the rise of the cost for health and medical care.

4. **Blue Cross/Blue Shield**
All too often Blue Shield policy is formulated by full-time staff without direction by the Board of Directors. For example, recently in testimony before the Legislative Commission on Certification of Need, Blue Cross and Blue Shield made the demand for inclusion of private physicians and their offices within this proposed legislation. This was a policy *not* presented to the Blue Shield Board of Directors.

5. **Policing Our Own**
We, as a profession. are responsible for those doctors among us who are ill from mental disease, alcoholism or drug abuse. It is my personal position that the incompetent physician should be removed from our ranks in the same manner as the "sick" doctor. An active approach, with the help of the medical licensing board, should be part of our Association's responsibility.
As a professional association, we are expected not only to support our colleagues but also to enforce ethical standards. This places us in the unique position of representing our colleagues while protecting the public.

CONCLUSIONS:

1. To those loud-voiced critics of medicine, I say: "Get off our backs."
2. We have acted responsibly before and we will continue to do so.
3. To American physicians I say: "Act responsibly—don't hospitalize patients without absolute need, and raise fees only when your costs demand it.

We can anticipate that Health Manpower, PSRO, HSA and Comprehensive Health Planning will provide the matrix for national health insurance. Today all of our ethical principles and scientific know-how are considered in the light of cost control. It is mandatory that we never allow the quality of medical care to be compromised by the health policy of uninformed federal bureaucracies or state legislatures—and I promise to fight toward this end with all the energy at our disposal.

Address of President of the ISMA Auxiliary
Mrs. David A. Goldsmith

ACTION: Filed.

Dr. Santare, Dr. Beeler, trustees, members and guests of the Indiana State Medical Association:

The Auxiliary desires to express to you, on this occasion, its sincere appreciation for this special honor of inviting the president of your Auxiliary to appear before you. As the 50th state president, and now being in the 50th year of our founding, I consider this a great tribute. Your evidence of appreciation of your Auxiliary has done more to encourage us to work harder to assist you in one of your most important fields of endeavour today, that of public relations.

I would like to, but shall not impose upon your generosity, to give a detailed accounting of the many ways we have been working to be of assistance to you. We are sure you are well aware of most of them. Because we are so proud of them, we must share a few highlights.

At our recent State Leadership Conference, we were fortunate in having Dean Beering explain the importance of unrestricted funds from AMA-ERF to I.U. School of Medicine so it can be used to establish Family Medicine, a model unit, and Nuclear Medicine. The advantage of an unrestricted fund is that money is deposited in a trust account where it is invested and earns interest. Every five years it is reviewed and updated. This year $40,000 was sent to I. U. School of Medicine. The national total collected by auxiliaries was $1.4 million as of June 1976.

We were thrilled with the results of the Health Manpower Bill. We wrote many letters to our Congressmen during the time that crucial decisions were being made, bringing details of the bill to their attention. Many members are currently working very hard to elect candidates who are friends of medicine. We are continuing what has become an annual "Meet Your Legislator Day" when auxilians from many countries have lunch with their legislators in Indianapolis.

I would like to give special recognition to two outstanding auxilians who are carrying out community programs in health education in Marion County schools. They are Mrs. William N. Ellis, and Mrs. Paul S. Lewis. They go to elementary grades and educate the children as to what are health careers, and explain physicians' most commonly used instruments.

Just in case you are not well aware of them, it might not hurt to give some information about SAMS—Spouses of American Medical Students. Mrs. Stanley Chernish and Mrs. Herbert Egbert have done a tremendous job in laying the ground work for our future auxilians. Mrs. Chernish has proudly served on the board of the AMA Auxiliary. Indiana also shares Mrs. Philip L. Smith on the National Board. We are very proud of them.

If I may, I would, however, like to tell you that we have a goal for the year of increasing membership and establishing auxiliaries in unorganized counties. Today we have 52 active counties with the possibility of organizing approximately 28 additional counties. We hope that by the end of this year, every county will be organized. If not, we hope that women who live in unorganized counties will be members-at-large. To do this we seek your help and assistance. In counties with a small number of physicians we need every doctor's wife as a member, in order to be an effective force for medicine. As you know, we cannot organize a county that has not first had the approval of the county medical society. Those of you here today, who are from counties not having an auxiliary, can be of tremendous assistance to us if you will but approve the organization of an auxiliary. It is then up to your organization to convince those in your county that an auxiliary can be an important asset to the medical profession and its program. We have the time, we are interested, and we want to help in any way that we can. If your wife is not already an auxilian, please encourage her to join. She can receive the publications and information that will help her help others in your community.

We gratefully appreciate the guidance and assistance of your president, Dr. Vincent Santare; our advisors, Dr. William Sholty, Dr. G. Beach Gattman and Dr. Jack Walker; Mr. Donald Foy and the ISMA staff. I look forward to my association with Dr. John Beeler, your president-elect. Thank you for the courtesy of inviting me, and I convey to you the appreciation of your Auxiliary for your recognition. Thank you.

Report of President, American Medical Student Association, Indiana Chapter
Walter R. Hunter

ACTION: Filed.

The past year has been an important

year for the American Medical Student Association (AMSA). The Indiana Chapter participated in national programs and continued the local programs and services provided in the past.

The Medical Education Community Orientation (MECO) Program was quite successful. In this program medical students who are accepted for participation spend eight to ten weeks in small community hospitals during the summer between the first and second year of medical school. In these hospitals a physician supervises the student as he rotates through the departments of the hospital and gains first hand knowledge of the practice of medicine in the small community. This year more than 30 students participated in the program in Indiana and AMSA appreciates the dedication and cooperation of the participating hospitals and physicians. We feel this early exposure to community oriented medicine can be a powerful incentive for students to seriously consider a primary care practice in smaller communities. The students participating in MECO have felt the experience to be invaluable, both as a medical training experience and for demonstrating the service and opportunities available in the smaller community.

Local services provided this year included the Student Phone Directory, which was published with the support of the Minnesota Mutual Life Insurance Company, which offers the AMSA Life Insurance Policy. AMSA also negotiated with an Indianapolis medical supply house and through these negotiations gained an additional 10% discount off the price of medical instruments for second year students.

At the national level, Indiana's Chapter sent five students to the National Convention of AMSA in New Orleans in March 1976. The Indiana State Medical Association provided financial support for this endeavor. Several issues were considered at this convention, the most important being resolutions calling for implementation of a national health insurance program with specific provisions to be covered in such an insurance program being included in the resolution and also a resolution calling for mandatory service by physicians after graduation in physician shortage areas. After much debate, both in reference committees and on the floor of the House of Delegates, the mandatory service resolution was defeated, but narrowly. Indiana went on record against the resolution. We also voted against the resolution calling for national health insurance with the specific provisions that were included in the resolution. However, this resolution was adopted by the House. We await further development of policy regarding these important resolutions.

The new officers for the 1976-1977 year were elected and are: Walter R. Hunter, Junior, president; George Alcorn, Junior, vice-president; Brian Davies, Sophomore, secretary; and William Pond, Sophomore, treasurer. Mark Ballard, Sophomore, is the new Project Director for the MECO Program, replacing outgoing director David Rardon, Junior. Mr. Rardon served the MECO Program very well and, with Mr. Ballard's previous participation in MECO, we feel he will continue the development and promotion of this program.

AMSA wishes to take this opportunity to thank all those of ISMA with whom I have been associated this past year for the help and suggestions offered for improving AMSA. A special thanks is in order for both the financial assistance provided toward expenses for attendance at the national convention and for the time allowed by the Executive Committee to talk with me and provide counsel as to the implications and effect that adoption of the previously mentioned resolutions would have on the national organization.

The medical students of Indiana University appreciate deeply the opportunity to be included in Indiana State Medical Association. We wish each member of ISMA peace and health in the coming year.

Address of Chairman of Blue Shield Board of Directors Joe M. Black, M.D.

ACTION: Filed.

Mr. Speaker, members of the House, fellow physicians, and guests:

It is indeed a privilege for me again to represent your Blue Shield Board here and I bring your attention to our bicentennial report. We have deviated from our usual format this year and brought to you a little history of medicine in Indiana along with the statistics of our operation. I also would like to apologize for leaving off a picture of our vice-chairman, a previous past-chairman of the Board of Trustees of the State Medical Association, and a long time board member, Dr. John Paris.

This year for sickness care, the Blues will handle approximately one billion dollars in cash flow for sickness care and PVM. Third, I would like to unequivocally state that your Blue Shield Board of Directors will oppose any legislation infringing upon the private practice of medicine or private enterprise.

Report of the Medical Licensing Board

ACTION: The subject of the physician assistant referred to commission on legislation.

This seven-member Board consists of five medical physicians, one osteopathic physician and one chiropractic physician. This Board is charged with examination and licensing of practitioners in several branches of the healing arts, including medicine, osteopathy, chiropractic, midwifery, physical therapy, physical therapist's assistants, and podiatry. In addition, the Board handles internship registration, issues temporary medical permits, temporary medical educational permits and teaching permits. Medical Chiropractic and Podiatry Corporations are also verified by this Board.

The Board is required to hold two meetings a year: The second Tuesday in January and July. The Board may and does set up a scheduled six official meetings a year; and also may set up special called Board meetings on demand. During the year Jan. 1, 1975, to Dec. 31, 1975, the Board held 11 official meetings; so far, for the year 1976, January to present date, Aug. 30, 1976 twelve meetings have been conducted.

The Board is in process of promulgating Rules and Regulations. At the present time, reviewing the staff operations with intention of adding the position of a Medical Director to be filled by a fully licensed medical doctor.

The Podiatry Board is a sub-Board within the structure of the Medical Licensing Board and consists of two licensed Podiatrists and three members of the Medical Licensing Board. The Podiatry Board holds two meetings annually and any additional meetings required to transact Podiatry matters. The Podiatry Board holds two examinations a year in the months of January and July. They also evaluate each application for licensure and makes recommendations to the Medical Board.

The Physical Therapy Advisory Committee, composed of three licensed Physical Therapists appointed by the Governor, meets with the Medical Licensing Board and makes recommendations. They evaluate each application for Physical Therapy and Physical Therapy Assistants for examinations and/or endorsement, and forward their findings and recommendations to the Board. They conduct three examinations each year.

The Board sets standards for approval for schools, and minimum requirements for licensing of applicants, and adopts rules and regulations governing licensing of practitioners in these various fields. Licenses procured by fraud or misrepresentation and/or held by those guilty of a felony, gross immorality, drug or alcoholic addiction may be revoked after notice and hearing.

Several fees are collected by the Board and deposited to the General Fund. Fees for the practice of medicine, surgery and obstetrics or osteopathy are as follows: Endorsement ($100.00), by examination ($85.00), repeat examination ($75.00),

endorsement to other states ($10.00), biennial renewal registration (resident and non-resident) ($20.00); reinstatement of expired license will be the delinquent fees (if any) penalty ($50.00); and current registration. Chiropratic fees are as follows: Endorsement ($100.00), by examination ($85.00), repeat examination ($75.00), endorsement to other states ($10.00), biennial renewal registration (residents and non-residents) ($20.00), reinstatement of expired license, delinquent fees (if any) penalty ($50.00), and the current registration. Podiatrists and Physical Therapists and Physical Therapist's Assistants pay a ($10.00) filing fee, Podiatrist examination fee ($25.00), Physical Therapist and Physical Therapist's Assistants ($35.00) examination fee and ($20.00) biennial renewal registration fee, endorsement of Podiatrist ($50.00), for Physical Therapists and Physical Therapist's Assistants ($35.00). Reinstatement for expired Podiatrist, Physical Therapist's and Physical Therapist's Assistants license is delinquent fees (if any), penalty ($50.00) and the current registration. Midwifery fees are as follows: Examination ($35.00); endorsement ($35.00); endorsement to other states is ($10.00); biennial renewal registration (resident and non-resident) ($20.00), reinstatement of expired license, delinquent fee (if any), penalty ($50.00), and the current registration.

The Board also registers interns, issues temporary medical permits to residents in training and issues temporary medical educational permits and teaching permits. Internship registration are issued at no cost. Temporary medical permits are $10.00 with a $5.00 annual renewal. Temporary medical education permits are $50.00 with a $10.00 annual renewal. Teaching permits are issued upon registration with the Board at no cost. Preceptorship certificates are issued for a period to be determined by the Board, but not to exceed two (2) years under an approved preceptor for a fee of ($10.00) each year.

The fees charged herein are the fees established by the previous Board by authority of Chapter 80 and I.C. 1971 Titles 22-25. Under Public Law 271, House Enrolled Act #1698, approved April 26, 1975, the Board is charged with promulgating Rules and Regulations and fixing fees for examination, permits, licensure and registration; and reinstatement of licenses and permits.

The Board administers the Federation of State Medical Boards Licensing Examination, an objective, multiple-choice comprehensive examination designed to test knowledge and ability in Basic Medical Sciences the Clinical Medical Sciences, and in Medical Competence in patient management, on Dec. 2, 3 and 4, 1975, and June 15, 16 and 17, 1976. The next State Board Examination will be given on Dec. 7, 8 and 9, 1976.

REPORT OF BOARD OF MEDICAL REGISTRATION AND EXAMINATION OF INDIANA

July 1, 1975 — June 30, 1976

HOUSE ACTION: Ordered filed.

Applications received for December, 1975, June 1976 State Board Examinations (Med.)	741
Ineligible to take State Board Examination for various reasons	1
Approved for December 1975, June 1976 State Board examinations	740
Failed to appear for State Board Examinations	151
Applicants taking State Board Examinations	589
Candidates failed the State Board Examinations	251
Candidates passed the State Board Examinations	336
Candidates from Indiana University Medical School taking State Board Examinations	259
Candidates from Indiana University Medical School taking State Board and failed	8
Candidates taking Doctor of Osteopathy Examination	18
Candidates taking Doctor of Osteopathy Examination, failed	6
Candidates from foreign medical and other schools taking State Board Examinations	309
Candidates from foreign medical and other schools, failed	237
Candidates from foreign medical and other schools, who passed	72
Over-all failure rate	20.0%
I.U.M.S. Graduate, failure rate	2.0%
Foreign medical school graduate, failure rate	76.0%
Candidates taking Chiropractic State Board Examinations	0
Candidates taking Physical Therapy Examinations	73
Candidates taking Physical Therapy Examinations, failed	5
Candidates taking Physical's Therapist's Assistant Examination	32
Candidates taking Physical Therapist's Assistants Examination, failed	1
Candidates taking Podiatry State Board Examination	1
Candidates taking Podiatry National Board Examination	12
Casdidates taking Podiatry National Board Examination, Licensed	10
Candidates, Podiatry, failed	3

	1973-1974	1974-1975	1975-1976
Applicants granted license in Indiana by endorsement/reciprocity	282	392	492
Applicants endorsed to other states (M.D.)	327	321	314
Applicants granted license in Indiana by endorsement/reciprocity (Osteopathy)	6	10	22
Applicants endorsed to other states (Osteopathy)	3	3	6
Applicants granted Physical Therapy license in Indiana by endorsement/reciprocity	27	20	19
Physical Therapists endorsed to other States	18	23	15
Applicants granted Chiropractic license in Indiana by endorsement/reciprocity	19	9	23
Chiropractors endorsed to other States	0	1	0
Applicants granted Podiatry licenses in Indiana by endorsement/reciprocity	5	2	27
Podiatrists endorsed to other States	0	2	1
Licenses reinstated (all groups)	368	167	277
Total Investigations (all categories)	65	58	87
Citations or Board Action during the year (all groups)	6	15	23
Suspension of License (all groups)			4
Revocations during the year (all groups)	3	1	2
Surrender of License (all groups)			4

TOTALS, BOARD LICENSURE:	1973-1974	1974-1975	1975-1976
M.D. (resident and non-resident)	8,985	8,922	9,733
D.O. (resident and non-resident)	292	311	345
Drugless (resident and non-resident)	105	86	81
Chiropractic (resident and non-resident)	384	363	386
Physical Therapy	609	495	582
Podiatry	220	307	344

Midwife	4	4	6
Physical Therapist's Assistant	35	68	99
Temporary Physical Therapy Permits issued	7	6	5
Temporary Medical Permits issued	65	22	66
Internship Permits issued	151	162	171
Temporary Medical Educational Permits issued	21	57	41
Temporary Physicians Permits issued	87	86	31
Medical Teaching Permits issued	4	2	0
Preceptorship licenses issued	88	82	36
Total Medical Corporations licensed in Indiana	851	961	1,115
Total Chiropractic Corporations licensed in Indiana	4	2	5
Total Podiatry Corporations licensed in Indiana	1	0	1
Total Physical Therapy Corporations licensed in Indiana	1	1	1

Malpractice Insurance Report
Gilbert Wilhelmus, M.D.

ACTION: Referred to the Board of Trustees so as to inform Membership.

Before I talk about malpractice insurance, I would like to state that I'm not talking for or against the insurance industry. I'm in the middle.

Now, let's talk about House Bill 1460, P.L. 146. How many cases have been filed since July 1, 1975—15 months ago? Nineteen cases against all health care providers in the state of Indiana in 15 months. Before that, it was sky-high. So the bill has helped. It's a landmark piece of legislation and let's not forget that. Right now we have the waters quieted.

We have a trial lawyer appointed to the Governor's Commission on Malpractice, of which I'm the chairman; and, gentlemen, trial lawyers are quiet. These men were on one side and we were on the other side. Now we're actually getting close to the middle. It's unbelievable. We are cooperating. We are getting someplace. So let's be careful what we say about the possible increase in insurance costs.

Let's remember this—it is a good law, but it is not perfect. It's going to hurt some people and it's going to show in your pocket this next year. For the simple reason, in our law the statute of limitation is two years and that two years is not up until July 1, 1977.

So what's happened here? The ISO (Insurance Services Offices) has asked for a 270% increase in medial liability premiums this coming year. The insurance commissioner has not made a ruling yet. He's talking about a 214% increase. That's a horrible amount. But we're talking about a relatively small group of doctors who are involved. Medical Protective is not in this group and they insure about 75% of the doctors in Indiana. Another 10% are covered by companies who set their own rates or who are covered by the risk manager pool. This leaves 15% who would be affected by such a large increase.

Now let me give you a reason why. What I'm showing you is a graph which I demanded from an insurance company. I asked and received total premium dollars on these companies, the full expenditure of litigation only. I didn't want a salesman's commission, salaries, utility bills. I wanted how much they are paying out to a doctor in litigation processes, legal fees, protection to doctors, etc. So this is what I'm giving you. The total fee income and the cost for defending cases only—no administrative expenses. When you analyze it, you can see what's happening. Because of the long-tail aspect they were losing money, so in 1969 they raised their premiums to compensate for the losses. In 1970 earned premiums showed they were making a little bit but not a whole lot.

Now I'm not pro-insurance, believe me, but we could go right on down the line and see it is creeping up every year. These are lawsuits—that's the reason the premiums have got to go up—to cover the losses they're anticipating from lawsuits. After July 1, 1977, the long tail will no longer come into play. So we ought to see a leveling off of premiums and probably a drop in them.

I hope I have explained why there is going to be an increase in premium. This does not mean that our law is not any good. Every state in the union would love to have it and are trying to get it. One trial judge in the state of Indiana ruled that our law is constitutional. The lawyers took the case and did not go through the regular channels but the judge said the law is constitutional and threw the case out. We are winners—let's get together—don't fight among ourselves.

Reports of Officers

Report of Executive Director
Donald F. Foy

ACTION: Filed.

First of all, I want to let you know how delighted and flattered I was to have been selected to succeed Jim Waggener as your new executive director. I assure you I shall do everything I can to justify the confidence placed in me and look forward to a long and productive relationship.

As I indicated when first coming aboard in February 1976, I planned to undertake an objective review of the Association's overall operation, making recommendations where necessary for consideration by the Board of Trustees. Some administrative changes have already been implemented while still others will be recommended to the Board in the near future. For example, the number of sets of minutes produced of each Board meeting has been reduced from three to one in the interests of eliminating unnecessary duplication and reducing costs. A new headquarters telephone system will be installed shortly which will be more efficient in terms of our present needs and at the same time less costly than our existing system.

One of my most important and immediate goals is to improve and strengthen the channels of communications between ISMA and its component county societies and with other health related organizations as well. Effective communications with its members is the key to survival for any organization.

We did want to have an opportunity to become better acquainted with how things have operated in the past before formulating specific recommendations for the Board. However, I do want to share with you several general goals which I envision for the Association.

1. *Membership.* State medical societies can no longer afford to be complacent with regard to membership. There is a compelling need for the Association to identify and develop additional tangible benefits of membership in order to make membership more appealing. At the same time we must publicize the merits of our existing package of benefits. Accordingly, your ISMA has embarked on the formulation of an ongoing membership recruitment, retention and development program. The results of our first membership letter and supplementary dues notice (third billing) have been most gratifying. It enabled ISMA dues-paying membership to exceed that of 1975 as well as surpass our projected income

budget. A detailed membership report will be included in a later issue of *The Journal*. Perhaps most significant is the fact that the membership letter brought back into the fold a number of physicians who had dropped their memberships back in 1974. An attractive brochure describing the benefits of ISMA membership will soon be available for distribution and will become part of the revamped information kit for new members.

2. *Income.* It is incumbent upon the Association to identify and develop new non-dues sources of income to supplement dues income. We simply cannot continue to raise dues indefinitely.

3. *Representation.* The Association must beome the physician's advocate. Its continuing viability will be based upon its ability to vigorously champion the rights and position of practicing physicians against the constant encroachments of government into medical practice.

4. *Political.* There is a strong need for ISMA to become a more effective and potent political force. This can best be accomplished by strengthening the Association's political arm. IMPAC; and activity along this line is already underway. Physicians need to become more actively involved in politics, but if time is an obstacle then they should lend their financial support. In order for IMPAC to be effective in playing the game of practical politics, it must be unencumbered by party labels and cannot afford to be perceived as the captive of any one party. It must be free to support candidates who support medicine's position on the issues.

5. *Legislative.* The Association has been quite successful with its state legislative program. The ISMA achieved national acclaim for spearheading landmark legislation (P.L. 146) to cope with the medical liability crisis. However, there is a recognized need to strengthen ISMA's liaison with Indiana's congressional delegation. Such liaison must be ongoing rather than merely periodic. The opportunity is available for ISMA to have a greater input into the shaping of important national policies which, in most instances, have more far-reaching impact on the practice of medicine than state legislation. Steps in this diretion have already been taken.

6. *Planning.* Anyone somewhat knowledgeable about medical care in this country has to wonder about the future of organized medicine and where it is headed! Consequently, a good deal of emphasis needs to be placed on planning. It's too easy to become so consumed in "fighting the alligators," so to speak, that one forgets that perhaps the most effective device for dealing with them is to drain the swamp. Medical associations can not afford to allow themselves to fall into this trap.

As busy practitioners you have a right to expect the appropriate long-range leadership from your state and county officers and your staff. It is the obligation of staff to facilitate intelligent decision-making and to assist in anticipating the future. If the practice of medicine as we know it today is going to survive in anything like its present form, your Association must remain vigilant and look ahead—perhaps five years ahead.

Your Future Planning Committee is attempting to do just that. In order to obtain base line data for evaluating members' needs and charting a course for the future direction of the Association, the Committee has developed a membership questionnaire. The Future Planning Committee has also developed a proposal for conducting a feasibility study concerning the Association's involvement in computer applications. It is the Committee's belief that ISMA should be the principal authority and agency in Indiana for the collection and dissemination of all physician-related data.

The Commission on Constitution and Bylaws will recommend to the House at the October 1976, meeting a new streamlined constitution patterned after that of the AMA. In the course of its revision efforts, the commission discovered much duplication of material between the present ISMA Constitution and Bylaws which leads to confusion and constant inconsistencies. This new approach would eliminate such duplications and incorporate the material currently contained in the Constitution into the Bylaws, thus simplifying understanding and readability.

This year there will be no commercial exhibits at the annual convention, thus enabling us to eliminate the necessity for renting the Indianapolis Convention Center. We will retain some scientific exhibits but they will all be accommodated in the headquarters hotel, as will be practically all the events associated with the convention. The commercial exhibitors have received this change of approach very well and many have pledged financial support for the scientific program in lieu of exhibiting. The elimination of commercial exhibits provides greater flexibility in the selection of future meeting sites.

Your executive director has felt extremely fortunate in having inherited a loyal and capable staff. This is an asset that can not be purchased but one that is critical to the success of any association. There is always room for improvements, however; consequently, current staff functions are being reviewed, which will undoubtedly result in certain realignment of responsibilites.

It is our intention to have the field service staff truly become the "eyes and ears" of the Association and a real extension of the headquarters office. They have been instructed to become even more involved in providing service to county and district societies in addition to serving as important communication links.

The headquarters building has taken on a new manicured look with the recent employment of a full-time maintenance man. The previous commercial cleaning service has been terminated and we now have an individual available on a full-time basis to handle the routine daily cleaning, attend to backlogged maintenance projects, perform minor repairs and a variety of miscellaneous chores.

We are convinced that the single most important issue facing organized medicine today and for the immediate future is rising health care costs. According to the President's Council on Wage and Price Stability: (1) Health care costs are rising much more rapidly than the overall rate of inflation in the economy. (2) The rising cost of health care is impacting the disposable income of every American family. (3) Health care costs are expected to rise sharply for the forseeable future. The Council has declared the rise in health care costs to be a major public policy problem for the nation.

Despite the fact that most of the increase in costs occurring during the past 10 years is explainable and should have been predictable, the proponents of a nationalized health care delivery system will use the rise in health care costs to demonstrate that the present system is out of control and, therefore, further regulation and cost containment mechanisms must be imposed. One way physicians might come to grips with this issue is by developing a cost conscious approach: that is, becoming better acquainted with the cost of the procedures ordered for patients and looking at the cost-benefit ratio. Of course, less costly decisions are more likely to be made in an atmosphere where the threat of malpractice is better contained.

The American Medical Association is concerned, along with everyone else, over mounting costs and, in recognition of this problem, recently formed a Commission on the Cost of Medical Care. This is a diverse group that includes representation from management, labor, consumers, health professionals, the insurance industry and Congress. The Commission will study the problem of rising costs and recommend private sector actions to hold down increases in medical care costs, hopefully, without jeopardizing quality.

Your medical profession is entering perhaps its most critical period and will be faced with many formidable challenges in the years immediately ahead. The pressures from government for tighter regulation and control of medical practice continue to mount. If the medical profession is to meet these challenges, there is a critical need for strong, aggressive and vigilant leadership, as ex-

emplified by medicine's very first lawsuit against government regulations—specifically, HEW's utilization review regulations. Organized medicine needs the active support of every practicing physician if it is to continue its fight against further government encroachments into medical practice, ensure the passage of sound legislation and defeat that which is irresponsible.

DONALD F. FOY
Executive Director

Actions and Disposition of Resolutions, 1975 House of Delegates

In accordance with the directive of the House of Delegates and the Constitution and Bylaws, your executive director lists herewith the disposition of actions taken by the 1975 meetings of the House of Delegates, Indiana State Medical Association.

RESOLUTION 75-1, CREATION OF A SECTION ON ORTHOPEDIC SURGERY

Action: Adopted. Referred to Commission on Constitution and Bylaws with the recommendation that a study of the question of creation of new sections be instituted.

Status: The Commission on Constitution and Bylaws has studied this matter during the past year and has included, in the revised format of the Constitution and Bylaws, procedures for creating new sections of the ISMA.

RESOLUTION 75-4, LOCATION OF AMA MEETINGS

Action: Adopted with the recommendation that AMA delegates introduce this resolution at the next AMA meeting.

Status: The resolution resolved that "until such time as the Association's resources permit the luxury of travel and transportation of staff and equipment, all meetings be held in Chicago, except for government-related activities which may be better served by a Washington location; and that scheduled sessions at distant sites be rescheduled for Chicago unless compelling and persuasive reasons can be advanced with appropriate fiscal data."

The AMA delegation introduced this resolution at the 29th Clinical Convention in December 1975. The resolution was not adopted. The AMA Reference Committee to which the resolution was referred recommended that "inasmuch as all interim meetings of the House of Delegates will be held in Chicago after 1977 and the present Board of Trustees' policy encourages all councils and committees to meet in Chicago, the intent of this resolution appears to be satisfied."

RESOLUTION 75-5, ISMA MEMBERS' INSURANCE PLAN

Action: Adopted with the resolve that the Indiana State Medical Association through its Commission on Medical Economies and Insurance shall further study the matter of an insurance program for all its members which would permit its members to purchase all types of insurance through a self-insurance program of the Indiana State Medical Association.

Status: A program which would permit ISMA members to purchase all types of insurance through a self-insurance medium is now being explored by the Future Planning Committee of ISMA.

RESOLUTION 75-7, TEL-MED

Action: Adopted as amended and referred to the Board of Trustees to determine the feasibility of funding and continuance of Tel-Med and directed that the Board ask for voluntary contributions.

Status: The President of the Association, in a personal letter to all United Ways in Indiana, solicited funds for Tel-Med and was successful, in a limited way, in getting contributions. Additionally the Board of Trustees supported the idea of imprinting upon the dues notices to members a request for a $25 voluntary contribution for Tel-Med. The total amount received from 1,243 members, as of July 31, 1976, was $30,765.

RESOLUTION 75-8, MEDICAL MUSEUM

Action: Adopted as amended. Referred to the Board of Trustees.

Status: The House asked that the Board of Trustees investigate voluntary contributions for this endeavor. The Board of Trustees authorized imprinting upon the dues notice a request for a $2.50 voluntary contribution. This total as of July 31, 1976, was $3,668.05, with 1,480 members contributing.

RESOLUTION 75-9, FEE INEQUALITY

Action: Substitute Resolution 75-9 was adopted with the resolve "that ISMA and its Board work for elimination of different fee schedules based on geographical regions and that the manner in which this is accomplished be to the benefit of both the physician and the patient."

Status: The Board continued study of this matter; there were no specific actions taken.

RESOLUTION 75-14, AMA POLICIES ON MEDICAL INFORMATION TO THE LAY PRESS

Action: Adopted with the recommendation that the AMA Delegates refer this resolution to the AMA. The resolution stated "that the Indiana State Medical Association seek from the American Medical Association adoption of a publication policy which requires advance distribution of information to physicians which may be applied by members of the public without consultation of their physician or may imply inadequacy of treatment delivered in accord with convention."

Status: The AMA Delegation introduced a resolution dealing with this subject at the AMA annual convention in Dallas. The resolution was rejected by the AMA House.

RESOLUTION 75-17, MEDICAL EXAMINER

Action: Adopted as amended. The resolution: "Whereas, in many instances law officials experience difficulty in determining a cause of death; therefore, be it resolved, that the Association cause to be introduced in the 1976 General Assembly a bill to create a medical examiner system in the state of Indiana."

Status: An effort was made to introduce the bill in the 1976 General Assembly but these efforts were unsuccessful. A new bill is currently being formulated by the legal counsel of the ISMA and plans are being made for introduction in the 1977 General Assembly.

RESOLUTION 75-35, VALID PATIENT-PLAINTIFF CLAIMS UNDER H.B. 1460

Action: Referred to the Board of Trustees to send to Indiana State Study Committee. The resolution read in part, "Whereas, patient-plaintiffs with obviously valid claims are not well served by the requirements that they elect to pay the attorney on a per diem or contingency fee basis at the time of employment; therefore, be it resolved that ISMA Board of Trustees seek to introduce legislation to postpone such a determination until after the Medical Review Panel has met, reviewed available information, and indicated if there is an obviously valid claim."

Status: The matter was referred to the Indiana State Study Committee.

RESOLUTION 75-37, CLAIMS-MADE TYPE OF PROFESSIONAL LIABILITY INSURANCE

Action: Adopted as amended. The resolve read, "Resolved, that the Indiana State Medical Association continue to investigate all forms of acceptable professional liability insurance in order to satisfy the individual needs of each practicing physician."

Status: The ISMA has continued through the year to investigate all

forms of insurance. The Board of Trustees heard a detailed report on claims-made type insurance from an insurance company representative and passed a motion to the effect that utilization of claims-made policies in Indiana be at the discretion of the insurance commissioner.

Report of Chairman of the Board Eli Goodman, M.D.

ACTION: As an addendum to the report of the Board, Resolution 76-29 was submitted for consideration.

The first meeting of the Board of Trustees, following the organizational meeting and election of officers which was held at the conclusion of the final meeting of the House of Delegates in October, was held on Nov. 16, 1975. Each meeting of the Board was characterized by a large number of items on the agenda to be considered.

The Board concerned itself greatly with the ongoing problem of professional liability insurance and assisted in the formulation and circulation of a questionnaire to obtain current data on the professional liability situation in Indiana. The request had come from the Governor's Study Commission on Liability Insurance.

In February the Board increased the mileage allowance from 10¢ to 15¢ per mile for all ISMA committee members attending meetings and official functions of the Association. The Board also increased, for one meeting only, the allowance for AMA delegates and alternates who would be attending the AMA convention in Hawaii.

In discussions of the 29th Clinical Convention of the American Medical Association the Board directed the AMA delegates to vote against national health insurance (described as government-sponsored, all-paid). The Board also directed the delegation to oppose a resolution which would have made the $60 assessment of members mandatory.

The Board also met with the AMA delegation prior to the AMA Annual Convention in Dallas and reviewed a multitude of reports and resolutions to be brought before the AMA House. Results of actions are contained in the report of the Delegates.

During the year, through action of the Board and submission of an application to the American Medical Association, the ISMA received a $25,000 grant to participate in a Jail Medical Care Project in conjunction with six other states. The purpose of the three-year project is to develop standards for certification in jails. Dr. Dwight Schuster is project leader in Indiana.

The Board also took action to incorporate in the dues billings to members a request for a $25 contribution for the Tel-Med program and also a request for a $2.50 contribution to the Indiana Medical Museum.

In December the Board employed Mr. Donald Foy as executive director of the Association. He officially took over his responsibilities on Feb. 1, 1976.

One of the many items discussed by the Board was the problem of health insurance carriers not paying for specific services to patients in doctors' offices while at the same time paying for these same services in a hospital. A Board committee was directed to look into this matter and seek solutions.

Dr. Lowell H. Steen, a trustee of the AMA, kept the Board posted on current activities of that Board, and district trustees of the Association also reported activities from their districts. Supported by the Board and the AMA delegation, Dr. Steen was successful in his bid for reelection as AMA trustee.

Certificate of need legislation was discussed periodically. The Board adopted a motion which stated that the ISMA opposes the current certificate of need legislation unless the physician is completely exempted from the act.

PSRO was a continuing matter of concern to the Board and the concept of a statewide PSRO as opposed to regionalized PSRO. It was moved by the Board that, if the inevitability of a PSRO were a fact, the ISMA favor a statewide PSRO over the regionalized concept.

The Board undertook a study of alternative proposals to the members' health insurance coverage currently provided by Blue Cross and Blue Shield and it was pointed out that ISMA members should be encouraged to select a major medical plan as opposed to the first-dollar coverage type of health care coverage.

Antisubstitution legislation was discussed, with the Board reaffirming its policy against generic substitution of prescribed drugs.

Changing the format of the ISMA Annual Convention also came before the Trustees who endorsed eliminating from the annual convention, for the first time, commercial exhibits. Scientific exhibits, however, it was decided, should be continued. In the discussion as to charging a registration fee to members who attended the Convention, the Board resolved negatively on this issue.

Confusion on the problem of "remission of dues" came before the Trustees. The terminology has been used throughout the years as applicable to retired, disabled or hardship status. The staff was directed to prepare a form based on definitions which would explain fully the categories of membership and dues status, so that when a change in status is requested, the county medical society could fill out the questionnaire which would be self-explanatory and simplified.

Concerning Health Service Areas, the Board moved that information concerning major events and changes which affect the medical aspects of membership in HSA be sent to trustees, alternate trustees and presidents of county medical societies by the executive directors of the HSA areas.

The Board learned that an accelerated program to increase membership in IMPAC would be undertaken. Current membership is 1,808. Additionally, IMPAC, in an effort to exchange information on health issues and candidates, has instituted meetings with representatives from the Indiana Hospital Association, Indiana Nursing Home Association, Eli Lilly and Company, Dow Chemical Corporation, the Chamber of Commerce, the National Association of Manufacturers and others.

The Future Planning Committee reported to the Board that plans are being made for conducting a membership opinion poll to solicit comments on the types of services members would like to have the Association provide. The Committee also reported that plans are in the development stage to conduct a feasibility study regarding computer applications. The concept, protocol and estimates for the study were to be presented to the Board at its August meeting.

Although the matter was taken for information only, it was suggested to the Board that the ISMA consider employing an individual or individuals to assist physicians and county medical societies in keeping informed on the broad spectrum of activities and actions of the three Indiana Health Service Area organizations.

This report does not explain all of the actions, considerations and deliberations of the Board which transpired during the past year, but it is intended to give membership and the House of Delegates a concept of the types of problems with which the Board must deal during its sessions.

Your Association has a Board which carries out its responsibilities conscientiously and much thoughtful discussion prevails before decisions are made.

I wish to thank the trustees for their assistance during the year.

Report of the Treasurer Arvine G. Popplewell, M.D.

ACTION: Accepted subject to final certification of audit. As an addendum to the treasurer's report, a voluntary contribution of $2.00 for the Medical Museum is to be included with the annual dues statement. This is to be an ongoing, continuing billing for each year.

INDIANA STATE MEDICAL ASSOCIATION
Statement of Financial Condition

ASSETS

	5/31/76	9/30/75
GENERAL FUND:		
Cash on deposit	$ 92,145	$ 80,279
Investments—at cost:		
U.S. Treasury Bonds—long term	35,103	55,103
U.S. Treasury Bills—short-term	709,398	254,402
Accounts receivable	32,412	49,160
Prepaid expense and miscellaneous assets	10,374	20,015
Office furniture and equipment—net of accumulated depreciation	27,731	22,982
	907,163	481,941
BUILDING FUND:		
Cash on deposit	4,880	3,769
Cash in savings account	7,930	7,726
U.S. Treasury Bills	253,212	237,656
Prepaid expense	1,833	567
Accounts receivable	344	
Headquarters property		
Land	69,188	69,188
Office building and improvements—net of accumulated depreciation	231,379	234,218
Rental properties—net of accumulated depreciation	76,153	75,008
	644,919	628,132
STUDENT LOAN:		
Cash in savings account	19,190	19,190
Certificates of deposit	20,810	20,810
	40,000	40,000
MEDICAL DEFENSE FUND:		
Accounts receivable	1,105	
Cash in savings account	34,962	31,167
U.S. Treasury Bonds—long term	25,069	25,306
	61,136	56,473
	$1,653,218	$1,206,546

LIABILITIES AND FUND BALANCES

	5/31/76	9/30/75
GENERAL FUND:		
Accounts payable	$ 23,376	$ 20,164
Accrued taxes		25
Dues payable to AMERF	20,433	20,910
Advances from AMA	9,278	9,278
Unearned portion of current year dues	433,602	131,163
Deferred Tel-Med contributions	29,063	
Contributions annual meeting—deposits	1,000	7,200
Lease contracts payable	845	1,091
Fund balance	389,566	292,110
	907,163	481,941
BUILDING FUND:		
Accrued taxes on rental properties	1,250	1,508
Damage deposits and accounts payable	495	1,831
Loans from members (non-interest bearing)	19,575	19,875
Fund balance	623,599	604,918
	644,919	628,132
STUDENT LOAN:		
Fund balance	40,000	40,000
	40,000	40,000
MEDICAL DEFENSE FUND:		
Fund balance	61,136	56,473
	61,136	56,473
	$1,653,218	$1,206,546

In previous years we have published an abbreviated report in the September issue and carried the complete audit in the January issue of *The Journal*. The reason for this was that the audit is not made until after the close of our fiscal year (Sept. 30) and is never available in time to submit to the House of Delegates.

As was done last year, I am presenting an unaudited report of the financial condition as of May 31, 1976, and the figures from the Sept. 30, 1975 audit, for comparison. I hope in this way it will give our members a more current review of the financial conditions of the State Association.

Report of Editor of The Journal
Frank B. Ramsey, M.D.

ACTION: Filed.

On the basis of estimates for income and expense for the fourth quarter of this fiscal year it is predicted that the deficit will be about $26,000. This is in relation to a budgeted deficit for this year of $41,610 and an actual deficit for last year of $32,104.

The smaller deficit is due to a combination of more income from subscriptions by senior members and non-members than was expected, together with a reduction in the printing bill of about $12,000.

There has been a reduction in number of pages of about 30%. Following a survey of journal contents, which was conducted during the fall of 1975, the Board of Trustees approved a plan to drastically reduce the size of *The Journal*. This was accomplished by eliminating features which were low in popularity and by limiting the size of the scientific articles.

The new look has been in effect for about six months. Its full effect has not been felt, since several scientific articles accepted prior to the new limits, are still to be published.

However, the limitation of scientific articles to two journal pages, except when the article is subsidized at the rate

of $100 per page for pages in excess of two, has been well accepted. Two articles have been written with the limit in mind, numerous articles have been rewritten and shortened to two pages, two articles which, by their nature, have required more than two pages, have been subsidized. When the backlog of longer articles has been published, the new editorial policy will produce shorter, more concise writings and will allow the publication of more articles, at a lesser expense.

The Journal is resuming the publication of professional cards, arranged by categories of specialties. This feature will provide a ready reference for members who are seeking specialty consultations. It will also provide a method by which members may contribute to the financial support of *The Journal*.

The Journal received the first place award in the 1975 Sandoz Journalism Program for state medical journals with circulations above 3,000. A plaque and a $500 award will be presented by a Sandoz representative at the first meeting of the House of Delegates.

First Trustee District

ACTION: Filed.



BERNARD B. ROSENBLATT, M.D.
Trustee

The First District Medical Society held its annual meeting on May 13, 1976, at the Evansville Country Club. Pre-meeting festivities included the First Annual Robert Acre, M.D., Golf Tournament, named in honor of the only physician ever to win the All-City Golf Tournament. Mrs. Acre, widow of the late Dr. Acre, made a special contribution which permitted golf balls to be provided tournament participants at no charge. Winners were Wallace M. Adye, M.D., low net, and William D. Ritchie, M.D., low gross.

Martin J. Bender, M.D., First District president, presided over the meeting. Dr. Bender called attention to the fact that medical executives from county medical societies throughout the state and from the ISMA office in Indianapolis were present at the meeting and would be attending an all-day session on May 14 to discuss common concerns. Those in attendance included, Don Foy. ISMA, Barbara Schilling, Marion County Medical Society, Hal Hefner, Marion County Medical Society, Kenneth Bush, ISMA, John Twyman, Lake County Medical Society, Larry Pickering, Allen County Medical Society, Robert Amick, ISMA, and Bob Sullivan, ISMA. Other guests included Eli Goodman, M.D., chairman of the Board of Trustees of the Indiana State Medical Association, and Mr. Herbert P. Dixon, vice-president, Provider Relations, Indiana Blue Cross-Blue Shield.

Speaker for the evening was Joseph Robert, Ph.D., author, lecturer, and past-president of two colleges in the state of Virginia. Dr. Robert spoke on a bicentennial theme. "The Physician and the Bicentennial: 200 Years of What?"

Several significant actions were taken during the business meeting. One of the most important actions taken was to incorporate the First Trustee District Medical Society. Thereafter, funds were transferred from the old unincorporated association, and by-laws were adopted.

The officers of the new association who were elected include Herman F. Rusche, M.D., president; James A. Marvel, M.D., vice-president; and Forrest F. Radcliff, M.D., secretary-treasurer. E. DeVerre Gourieux, M.D., was re-elected alternate trustee. Ralph F. Carlson, M.D., was reelected to a three-year term on the Indiana Blue Shield Board of Trustees.

Those present heard a report from Dr. Carlson. He mentioned the need for cost control in health care, pointing out that 10% to 20% of family income in 1975 went for health care expenditures; 20 years ago, family health care expenditures were half that amount. Dr. Carlson also noted that all Blue Shield plans received subpoenas to answer charges that they were acting in restraint of trade because they were excessively controlled by physicians.

Dr. Rosenblatt reported as First District trustee and made a special plea for members of the Society to let him know those areas in which they feel ISMA should be active. He remarked that he cannot be responsive to the real needs of the membership unless he is made aware of them, and he invited suggestions from the membership at any time.

BERNARD B. ROSENBLATT, M.D.,
Trustee

Second Trustee District

ACTION: Filed.



PAUL W. HOLTZMAN, M.D.
Trustee

The second district has returned to our "pre-malpractice law" existence of "let the boys who are interested in medical politics handle it." National health insurance, which could be a problem, has been quiet because of an inability of the government to fund the program. When our state delegation visited Washington, little interest in new laws regarding health legislation was encountered and the general attitude seemed to be "when Congress gets the money, they will bury you." Congress has that capability now with existing laws.

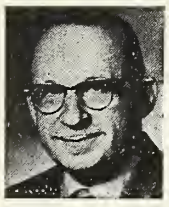
PSROs, HMOs, and HSAs have been kicked around and are still a real threat. AMA attitudes have been criticized—usually by the poorly informed.

We, as physicians, are presently not being threatened financially and are accordingly—like ostriches—burying our heads in the sand.

PAUL W. HOLTZMAN, M.D.,
Trustee

Third Trustee District

ACTION: Filed.



ELI GOODMAN, M.D.
Trustee

The Third District, during the course of this year, held a meeting in conjunction with the Indiana State Medical Association Auxiliary at the Marriott Inn in Clarksville on Apr. 20 and 21, with a short business meeting at 3 p.m. on April 21. This was thoroughly enjoyed by all.

The regular annual meeting is scheduled at French Lick Sheraton Hotel on Sept. 11 and 12. The program will begin on Saturday afternoon with an update on the Use of Antibiotics and Use of Laboratories. Dinner will be served Saturday evening and there will be a brunch Sunday morning followed by a discussion of Parenting Problems in the Vulnerable Child, by Morris Green, M.D., Indianapolis.

The business meeting of the ISMA District will be at 4:30 p.m. on Saturday, Sept. 11. It will be necessary at this meeting to elect a District Trustee. The business meeting of the Academy of Family Practice, with whom this will be a joint meeting, will be at 5 p.m. on Saturday.

During the past year your Trustee has been serving as chairman of the Board of Trustees and has been deeply involved with the many problems facing organized medicine today. I have done my best to continue to represent our District involvement in professional liability insurance, PSRO, utilization review, reimbursement and these and many other items have kept your Trustee a rather busy individual during the past year.

As I will not be eligible for reelection, having completed two terms of service to you, I wish once more to express my

gratitude for your confidence in me and allowing me to represent you as your trustee for the past six years.

ELI GOODMAN, M.D.,
Trustee

Fourth Trustee District

ACTION: Filed.



HOWARD C. JACKSON, M.D.
Trustee

The annual meeting of the Fourth District Medical Society was held at the Greensburg Country Club in Greensburg on May 5, 1976. The business meeting was at 4 p.m. and Dr. Ivan Lindgren of Aurora was elected president; Dr. Larry Williams of Madison was elected vice-president and Dr. Gerald Bowen of Lawrenceburg was elected secretary-treasurer. Dr. William Blaisdell, alternate trustee, announced that he would not seek to succeed himself and Dr. Mark Bevers of Seymour was nominated for alternate trustee and subsequently elected. We welcome Dr. Bevers. Mr. Donald F. Foy, executive director, ISMA, spoke at our meeting of the benefits occurring to physicians by virtue of their membership in the AMA and ISMA. We all hope that those benefits will increase in the coming years and we know that they would if we all become interested and participate in our societies and associations. Dr. Vincent J. Santare, president; Dr. John W. Beeler, president-elect and Dr. Eli Goodman, chairman of the Board of Trustees, also were present and took part in our meeting.

The trustees have debated and evaluated several ventures of the ISMA, some successful and some not so successful, during the past year. The Medical Liability Act, the Medical Practice Act, Tel-Med and the Indiana Medical Museum are some of our successes. I ask everyone by your voluntary contributions to support Tel-Med and the Indiana Medical Museum.

I alert you to possible drastic, divisive and detrimental changes to come in Blue Cross-Blue Shield. Government interference in medicine has been our major concern for the past 10 years and we have continually lost ground to its invasion. The past year has seen the Federal Trade Commission playing against our advertising policy, the publication by the House of Representatives of their evaluation of unnecessary surgery and the designation and activity of the Health Systems Agencies. Even in the fraternity of medicine, we find the pharmacists asking for repeal of antisubstance laws. We need, and I ask everyone, to become united in our deliberations and actions. We need, and I ask everyone, to trust and cooperate with one another.

HOWARD JACKSON, M.D.,
Trustee

Fifth Trustee District

ACTION: Filed.



CLEON M. SCHAUWECKER, M.D.
Trustee

On May 28th, members of the Fifth District and their wives met at the Elks Club at Brazil. Among the guests present were Dr. Eli Goodman, Dr. Peter Petrich, Mr. Foy, Mr. Dixon, and Mr. Amick. At the business meeting, Dr. Bill Bannon was reelected alternate trustee; Dr. Wm. Strecker, who was appointed to fill the unexpired term of Dr. Johnson as our representative on the Blue Shield Board of Trustees, was elected to that post. The officers for the coming year are: Dr. Fred Dettloff, president, Dr. Greg Larkin, secretary-treasurer—both fom Greencastle. The meeting next year will be at Greencastle—time and place not yet set.

The main speaker of the evening was Representative John Meyers, whose main topic concerned the difficulties of getting proper legislation passed, and the woes of the Congressman. A lively question-and-answer period followed the presentation.

The best joke of the evening was overheard during the Happy Hour—and was attributed to Bob Hope—who was supposed to have stated that he could see no reason for the excitement being produced by the antics of Representative Hayes and Ms. Ray, because after all, she was only doing to congressmen what congressmen have been doing to the American public for years and years.

CLEON M. SCHAUWECKER, M.D.,
Trustee

Sixth Trustee District

ACTION: Filed.



PAUL M. INLOW, M.D.
Trustee

I will be concluding my term of office as trustee from the Sixth District at this annual meeting of ISMA. It has been an honor to serve the physicians of the Sixth District and I have enjoyed the friendships made at the state level. Glen Ward Lee, M.D., from Richmond, will be the new trustee from the Sixth District with Davis W. Ellis, M.D., Rushville, as alternate trustee.

The Sixth District Medical Society met at Westwood Country Club, New Castle, on May 12, 1976. Our speakers were H. Pete Hudson, insurance commissioner of the state of Indiana, who spoke on our new malpractice legislation, and Donald Foy, Executive Director of the State Medical Association, who talked to us about present and future services to the membership. The dinner speaker was Richard Lugar of Indianapolis, candidate for the U. S. Senate. C. G. Clarkson of Richmond was elected president of the Sixth District with O. L. Webb elected vice-president. Hancock County will designate the secretary-treasurer.

I plan to continue to serve Indiana State medicine by participation at the Commission level. We have taken a giant step forward in our attempt to solve the malpractice insurance problem in Indiana but we are far from a total solution. I am again personally involved in an attempt to find insurance in the open marketplace because of withdrawal of the company which previously wrote my malpractice insurance. This may involve paying two and one-half to three times the dollar amount for the same coverage which I enjoyed this past year. I hope that my fellow physicians are spared this nervewracking experience, but if they are so involved, urge them to report their experiences to the Study Commission of the Indiana State Legislature.

P. M. INLOW, M.D.,
Trustee

Seventh Trustee District

ACTION: Filed.



JOHN O. BUTLER, M.D.
Trustee



JOHN G. PANTZER, M.D.
Trustee

The annual meeting of the Seventh District Medical Society was held at the

Hillview Country Club in Franklin on June 9, 1976. The beautiful spring weather provided a perfect afternoon for 20 golfers. The day was also ideal for several of the ladies who enjoyed a card and pool party at the home of Dr. and Mrs. John Records.

Dr. John Records, Seventh District president for 1975-76, presided over the election in which Dr. William Stafford of Plainfield was selected president-elect and Dr. Malcolm Scamahorn of Pittsboro was elected to succeed himself as secretary/treasurer.

We were honored to have Governor and Mrs. Otis R. Bowen, M.D. as our guests. Following dinner, Governor Bowen spoke of state regulations and the need for regulation to be based on reasonable laws. Speaking of his administration, Dr. Bowen said, "Our goal has been one of building the level of the quality of regulated services to the public, primarily through the voluntary positive efforts of the industry where that can be done, and by punitive legal action where we must."

Continuing his theme, Dr. Bowen reported on his participation as the only gubernatorial member of the President's Commission on Federal Paperwork and posed the question "Why work to streamline forms and cut down hassle if there is no valid need for the information at all?"

The society was pleased to have among its guests Dr. Vincent Santare, ISMA president; Dr. Eli Goodman, chairman of the ISMA Board of Trustees; Mr. James Waggener ISMA executive secretary emeritus, and his wife Norma; Mr. Donald Foy, ISMA executive director; and Mr. Bob Amick, ISMA field representative.

The meeting provided an excellent opportunity for the recognition of Mr. Waggener by the Johnson County Medical Society. Mr. Waggener, whose distinguished career began in Franklin, served twenty-seven years as ISMA executive secretary through Feb. 1, 1976. An engraved plaque and a silver compote were presented to Mr. and Mrs. Waggener to mark Jim's election to honorary membership in the Johnson County Medical Society.

A solemn moment of silent prayer was offered in memory of our good friends, Dr. Fred Toumey and Dr. Malcolm Wrege, members of the Marion County delegation who had recently been taken from our midst. Their devoted service to medicine and its organizations will not soon be forgotten.

JOHN O. BUTLER, M.D.
JOHN G. PANTZER, M.D.
Trustee

Eighth Trustee District

ACTION: Filed.



JACK M. WALKER, M.D.
Trustee

There has been very little of an unusual nature occurring in the Eighth District of the ISMA.

The Eighth District annual medical meeting was hosted by the Madison County Medical Society and was held at the Anderson Country Club on June 2, 1976. The meeting was very well attended, and the dinner meeting was addressed by senatorial candidate Richard Lugar.

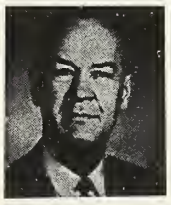
At the business meeting Dr. Donald R. Taylor was reelected to his position on the Blue Shield Board, Dr. Ted Doles was elected alternate trustee from the Eighth District, Dr. Clarence Ashburn was elected president of the Eighth District Medical Society, and Dr. David Dietz was elected secretary-treasurer of the Eighth District Medical Society.

The meeting in 1977 will be hosted by the Delaware County Medical Society.

JACK M. WALKER, M.D.
Trustee

Ninth Trustee District

ACTION: Filed.



WILLIAM M. SHOLTY, M.D.
Trustee

Thinking back over six years as ISMA Ninth District Trustee I am aware that many outstanding things have been accomplished; important decisions have been made and there are also many problems arising. The vicious, ugly movement toward Marxist medicine is frequently the main underlying cause of most of the problems facing medicine today. Your ISMA is dedicated to do all possible to maintain and preserve the free practice of quality medicine. One gets a sense of gratification from having participated in the sincere effort of finding solutions to the problems that have arisen. We hope and pray they have been correct.

I would like to urge all ISMA members to actively participate in their local county, state and national organizations. Become informed. Find out what is going on. Let your opinions be known and fight the constant pressure from the left. The ISMA is a fine, powerful organization that can and will help you.

The Ninth District is composed of 12 counties strung out from Lake to Vermillion County and from the Illinois state line to Madison County. Distance and physician population are a problem. This year Tippecanoe County hosted the district meeting for Tipton County. The golf meet was held at the Purdue South Course, the meeting and dinner were held at the Hilton Inn on June 3. Dr. John Knote conducted the meeting. Introduction and remarks of guests included Dr. Vincent J. Santare, president, ISMA: Dr. John W. Beeler, president-elect; Dr. Eli Goodman, chairman of the Board, Dr. James A. Harshman, Eleventh District trustee; Mr. Donald F. Foy, executive director, ISMA and Mr. Herb Dixon, professional relations, Blue Shield.

The subject of Tel-Med was brought up by the Trustee. A resolution was made, seconded and passed that the House of Delegates increase the ISMA dues an appropriate amount to finance the Tel-Med program and that this money be designated solely to finance the Tel-Med program.

Another motion was made, seconded and passed that the Ninth District call for a more explicit definition and specific functions of the Medical Audit Review Committee. A number of problems have developed in this regard.

Dr. Peter R. Petrich, Ninth District Blue Shield representative, reported that Blue Shield's losses this year will be less than expected.

A number of committee and commission reports were given by Drs. Kenneth Ahler, William Ferguson, Peter R. Petrich, Lindley Wagner, John Knote and Paul Honan.

Dr. John Knote was elected Ninth District trustee to succeed Dr. William M. Sholty. Doctor Petrich was reelected Ninth District Blue Shield Board member. Dr. Max Hoffman will continue as alternate trustee.

The dinner was well attended and the program was given by Professor Hans Adolph Heinrich of the Public Relations Department of Argonne Laboratories in Chicago.

I would like to state that I consider it an honor and privilege to have had the opportunity to serve the medical profession as Ninth District Trustee and I am sure that the doctors will extend the same cooperation to the new trustee.

WILLIAM M. SHOLTY, M.D.
Trustee

Tenth Trustee District



MARTIN O'NEILL, M.D.
Trustee

The last annual meeting of the Tenth Trustee District was held Sept. 24, 1975, at Valparaiso Country Club. Dr. J. M. Siekierski, president, presided and introduced the officers present. In the election that followed these officers were reelected for another term. They were Dr. Siekierski, president; Dr. James R. Brown, secretary-treasurer; Dr. Leonard W. Neal, alternate trustee, and Dr. William J. Fitzpatrick, representative to Blue Shield Board. Trustee Martin J. O'Neill was also introduced and spoke briefly concerning the Indiana malpractice act and urged members to attend the annual ISMA meeting in October at French Lick. The president of the Lake County Medical Society, Dr. Walfred Nelson, and Dr. Leon Armalavage, president, Porter County Medical Society, were introduced along with Dr. Thomas C. Tyrrell, alternate AMA delegate; Dr. Lee Trachtenberg, president Calumet Area Foundation for Medical Care; Mr. John Twyman, executive director, Lake County Medical Society; Mr. Charles Shoemaker, executive director, Calumet Area Foundation for Medical Care, and Mr. Howard Grindstaff, field secretary of ISMA. There were several guests present at the business meeting, including Dr. Ernest R. Beaver, president, Indiana Medical Licensing Board; Dr. William M. Sholty, Ninth District trustee; Dr. Peter R. Petrich, alternate AMA delegate and past president of ISMA, and Messrs. Gary Miller, Phil Sizelove and Bill Kelly of Indiana Blue Shield.

Area members of the Indiana General Assembly were invited to this meeting and those present included Representative Phillip Bainbridge, Speaker of the House of Representatives, and Mrs. Bainbridge (who incidentally won the door prize—a Polaroid camera); Representative and Mrs. Chester Dobis; Representative and Mrs. Jewell Harris; Representative and Mrs. Jerry Reppa; Representative and Mrs. Walter Roorda; Senator and Mrs. Ralph Potesta and Senator and Mrs. William Christy. Representative Bainbridge discussed the malpractice law and the Medical Practice Act during the business meeting.

Dr. Vincent Santare, president-elect of ISMA, was introduced and discussed a number of matters coming before the House of Delegates at the French Lick meeting.

Dr. Lowell Steen, newly elected to the Board of Trustees of the AMA, was introduced and spoke of the new militant stance of the AMA with regard to federal interference through regulation of the medical profession.

There was a golf tournament with prizes awarded to Dr. Joel Hull, low gross, Dr. Kumpoz Dennison, low net, and Dr. Paul Alvarez, closest to the pin.

Mrs. Vincent J. Santare presided over the ladies' program in the afternoon and there was entertainment following the dinner.

It was a good meeting, with 110 people in attendance. The next annual meeting will be Sept. 8, 1976, at Woodmar Country Club, Hammond and we hope to have a larger attendance.

New county society officers were elected during the year. Dr. Lambro Dimitroff was chosen president of Lake County Medical Society and Dr. David E. Ross, secretary. Porter County Medical Society elected Dr. Frederick D. Hoham president, and Dr. James R. Brown secretary. Both societies, along with the Calumet Area Foundation for Medical Care, have been active in the areas of CHP, HSA, HMO-IPA, and PSRO. The Calumet Foundation was denied a grant for an HMO feasibility study and later discussed the advisability of submitting an application for a planning grant for a HMO-IPA. This may be done at the opportune time. At the present, we have been informed that there is no money available from HEW for this purpose.

An in-depth hospital utilization study is being done by the Coordinated Care Program Committee (CCP) of Calumet Area Foundation for Medical Care. This committee was formed as a result of a contract with Inland Steel to do such a study, and most Lake County hospitals are involved in the project with physician-advisor subcommittees in each hospital. The cost of the study is borne by Inland Steel and the data gathered is, primarily, for information only.

The physicians in the Tenth District are very proud to have two outstanding medical leaders in their membership; namely, Dr. Vincent Santare, president of ISMA, and Dr. Lowell Steen, past president of ISMA, who was recently reelected to the AMA Board of Trustees. Both of these doctors are exceptionally well informed, articulate, and, apparently, have boundless energy, judging from the hours they spend performing the tasks they have undertaken. We express our thanks to them and look forward to their continued leadership in the troublesome time ahead.

MARTIN J. O'NEILL, M.D.
Trustee

Eleventh Trustee District

ACTION: Filed.



JAMES A. HARSHMAN, M.D.
Trustee

Since last October, much of organized medicine's energies have been diverted to the courtroom. A challenge to the constitutionality of our new law on professional liability insurance has been filed in a Marion County court. On the national scene utilization regulations are still in the news. As of the writing (July 15) final regulations have not been published. If they are similar to those published in the preliminary filing, the AMA will probably reinstitute its suit against HEW.

Several states and the AMA have challenged the constitutionality of P.L. 93-641, the National Health Planning and Resources Development Act of 1974. The Federal Trade Commission has filed two charges against the AMA, and both will probably be heard this year. One charge against the AMA is that its Code of Ethics prohibiting advertising is in restraint of trade. The FTC has not achieved truth in advertising for products. It is almost inconceivable to think they could achieve truth in advertising for something as intangible as a professional service. The other FTC charge against the AMA asserts that the AMA controls the number of physicians by limiting admissions to medical schools through its accreditation program and thus violates restraint of trade laws.

National Health Insurance may be one of the major bills debated in the next Congress, depending on the next occupant of the White House. One political party has already indicated that the enactment of NHI will be one of its early high priority bills in the next congress.

There is no question that the physicians in the 11th District, and in the rest of the country for that matter, have as their major concern today the interference of big government between their patients and themselves. This interference is growing daily by leaps and bounds.

Both the ISMA and the AMA have recently reorganized their committee and council structures. Hopefully they can react to the needs of our members in a rapid and effective manner. The tasks they face are of great magnitude and of great importance. Our future may be determined in the next year.

Last September, Carroll County was the host for the 11th District Medical Society in Delphi. The meeting was well attended. Dean Andrews of Purdue Uni-

versity was guest speaker for the evening. Dr. Richard G. Blair of Huntington was elected president, and Dr. Fred Poehler of LaFountaine was reelected secretary of the District Society. Dr. James A. Harshman of Kokomo was reelected trustee. The next District meeting will be held on Sept. 15, 1976, in Huntington and the Huntington County Medical Society will be host.

JAMES A. HARSHMAN, M.D.
Trustee

Twelfth Trustee District

ACTION: Filed.



The 12th District Medical Society will meet Sept. 9, 1976, at the Fort Wayne Ramada Inn. Featured speaker is Governor Otis Bowen. The women's program concerns (for the Bicentennial year) frontier homemaking, arts and crafts.

The 12th district officers this year were: president: Robert J. Edwards, M.D.: vice president: Karl Schlandemann, M.D.; secretary-treasurer: Tom Felger, M.D.; trustee: Alvin J. Haley, M.D.; alternate trustee: Franklin A. Bryan, M.D.; Blue Shield Board: Harry Tunnell, M.D.

The above officers met three times during the past year to plan for the annual meeting and attend to regular business. I would like to see these officers meet on a regularly scheduled basis, perhaps with the delegates attending. I feel this extra effort is necessary to improve communications, plan for our district's position at the annual ISMA meeting and make the trustee's position truly representative.

The board of trustees meets regularly every two months with special meetings added. Last year's major business was malpractice legislation; this year's most important business appointing Mr. Donald Foy executive director of the ISMA, a much happier involvement! Mr. Foy is assuming his duties very capably. I am sure he will become a mainstay to the ISMA.

Another shining moment was the election of Lowell Steen, M.D., to trustee of the AMA. Our AMA delegation worked hard for his election. Marvin Priddy, M.D., an alternate delegate to the AMA (from the 12th district), served admirably.

Uneasily, I observe the Board of Trustees becoming more "corporate." I would rather bend the corporation laws to make the Board more representative.

Specifically, legal advice would call for the Board of Trustees itself to make appointments to fill its own vacancies. Such advice would do away with the office of alternate trustee, also. Franklin A. Bryan, M.D., has been exceedingly helpful to me; I would hate to be trustee without back-up. Furthermore, other alternate trustees have made important contributions.

The Board of Trustees is more than a board; it sometimes performs as a cabinet, sometimes as a senate. In short, the board of trustees has the anatomy of a board but the physiology of a senate. I would prefer a board controlled by the districts rather than allowing a chance for the board to control itself. Which would you prefer?

The AMA continues fiscal improvement; likewise, it maintains its recent aggressive stance towards federal intervention in health care delivery. For instance, the AMA will join a state to sue the federal government to block the Health Services Agencies law. This on the basis that the "powers reserved to the states" section of the United States Constitution is violated by the "certificate of need" portion of the HSA law. (This section requires a state to demand a health care agency to complete a "certificate of need" showing a need for its planned facility with its state.)

Part two of the HSA law establishes regionalized planning panels composed of a consumer majority, thereby creating two more problems:

1. Planning has a tendency to become management (or worse, mismanagement) as demonstrated by the HSA's predecessors, HPCs.
2. Consumerism has its limits, too. Consumers are great in pointing out problems but weak in solving them because of lack of expertise in health matters, hypersensitivity to medical pressure groups and inattention to health-care politics.

My term is at an end. I have enjoyed being your trustee. You here at home and those in Indianapolis have been courteous, intelligent, diligent and helpful.

ALVIN J. HALEY, M.D.
Trustee

Thirteenth Trustee District

ACTION: Filed.



G. BEACH GATTMAN, M.D.
Trustee

The 13th Medical District Meeting was held at the South Bend Country Club September 9, 1975. The afternoon was full of golf, tennis, and bridge for the ladies.

The official meeting was chaired by John O. Hildebrand of South Bend, president of the 13th district. The report of the Secretary-Treasurer was given by Dr. David Spaulding of Mishawaka. The trustee report and reports of commission members who were pesent were given. Dr. Francis Kubik, Blue Shield representative, gave his report and Dr. Donald Chamberlain, alternate trustee, who is chairman of this area PSRO brought us up to date on progress in this area.

Dr. Vincent Santare, president elect of the ISMA, gave a short address. We also welcomed Mr. James Waggener, executive secretary, Dr. Thomas C. Tyrrell, alternate delegate to the AMA, Mr. Howard Grindstaff, field secretary ISMA, and Mr. Herbet Dixon of Blue Shield.

Election of officers followed: Dr. John W. Luce, Michigan City, president; Dr. Elmer R. Billings, Elkhart, president-elect; Dr. David Spaulding, Mishawaka, reelected secretary-treasurer; Dr. Francis Kubik, Michigan City, re-elected Blue Shield representative.

The evening program following a delicious New Orleans smorgasbord was by the Gaslight traveling group.

The next meeting of the 13th district will be Sept. 10, 1976, in Michigan City. Dr. Luce promises an interesting program for our 1976 meeting.

G. BEACH GATTMAN, M.D.
Trustee

Delegates to AMA

ACTION: Filed.

Indiana's delegation to the American Medical Association's House of Delegates meeting in Dallas was successful in its efforts to elect Dr. Lowell H. Steen to a full three-year term on the Board of Trustees.

Dr. Steen, a former president of the Indiana State Medical Association, served a one-year term on the Board before his reelection.

Cleveland family practitioner John H. Budd, M.D., was chosen president-elect of the Ameican Medical Association at this 75th annual meeting of the House.

The AMA's new president-elect has been a member of the Board of Trustees for the past six years and was a delegate to the House from Ohio for 10 years before that. He is a commissioner to the Joint Commission on Accreditation of Hospitals and a past president of the Cleveland Academy of Medicine.

AMA delegates renewed their support for the Association's Medicredit proposal for national health insurance, but decided against seeking legislation to guard against the cost of catastrophic illness.

Debate on NHI highlighted various

legislative proposals that came before the house in its closing hours. Discussions thus were on familiar terrain as delegates reiterated their opposition to the encroachment of government upon medical practice.

Simply put, most delegates would have the least objectionable form of government interference possible.

The support for Medicredit marked the eighth straight year delegates have endorsed the Association's proposal of tax credits to offset the purchase of comprehensive health insurance.

Medicredit would build on the existing system of private health insurance and is in stark contrast to proposals such as Kennedy-Corman that would federalize the medical care system into a monolith administered by the Social Security Administration, supported by compulsory payroll taxes and estimated to cost as much as $90 billion annually. Medicredit, the least costly NHI proposal, is estimated to cost $2.5 billion annually.

Although Medicredit was supported, some delegates urged that AMA drop any and all NHI proposals. This is the view of most grass-roots physicians, they argued.

Catastrophic health insurance, both free standing and supplementary, generated much debate on the floor of the House. The Board of Trustees was directed to proceed forthwith to design and have introduced legislation to provide for universally available catastrophic insurance coverage financed through and administered by the private health insurance industry.

In addition to NHI, the House wrestled with the whole panoply of government programs that they consider unwarranted interference in medicine.

The alphabetical bugaboos include HSAs (health systems agencies), HMOs (health maintenance organizations), PSROs (professional standards review organizations). Also, there is the Medicare-Medicaid Administrative and Reimbursement Reform Act, that would restrict the billings of hospital-based physicians, and the Federal Drug and Devices Act, that provides for fines for prescribing a drug for a use other than what is indicated on the package insert.

On each issue the House expressed its dissatisfaction and directed the board to pursue ameliorative action.

The House approved model state legislation to protect the confidentiality of medical records and to assure medical discipline.

Delegates opposed any regulations or legislation that would unfairly limit physicians' fees. At the same time, they condemned any fraud or wrongdoing by physicians under government medical programs, called for prompt prosecution of those charged with wrongdoing, and offered to assist in bringing an end to such activities.

The House strongly objected to the recent "rollback" of CHAMPUS fees. It urged members to bill CHAMPUS patients directly rather than accept the rollback to the 75th percentile of the Medicare payment formula.

In recognition of the increasing legislative activities by optometrists to obtain statutory authority to prescribe and apply eye medications, the House reaffirmed its policy that only physicians are qualified to prescribe and apply such medications, and called for efforts counteracting the optometrists' thrust.

The AMA House reaffirmed—in strong terms—its opposition to utilization review of hospital admissions within 24 hours, whether by federal PSRO regulation or rules of the Joint Commission on Accreditation of Hospitals (JCAH).

The House also adopted a policy concerning payment of physicians for utilization review. "When UR committees which are mandated by government or third party payors to review inpatient care require inordinate amounts of physician time and/or responsibility, compensation for the physician involved should legitimately be claimed."

In accepting a number of AMA budget reports, the House commended the trustees for their outstanding service in elevating the Association from the financial morass into which it had plunged in late 1974.

Jere W. Annis, M.D., the board vice chairman, reported that AMA has a current full dues-paying membership of 137,023, within close range of the 144,-500 figure upon which the 1976 AMA budget is based.

After several years' of study the delegates finished the arduous task of reorganization of the AMA's councils and committees. In addition, the office of the vice president was abolished.

In urging strong efforts to recruit additional members by year's end, Dr. Annis said that this would allow the AMA to apply about $10 million to its liquid reserves, bring the total by Nov. 30, 1976, to $18.2 million.

This is in keeping with the Association's determination to replenish its reserves, as directed by delegates at the 1975 Annual Convention, when dues were raised from $110 to $250 annually.

The House directed the board to take appropriate action—including legal action if needed—to guard against unwarranted federal intervention when the final utilization review regulations are published this fall. The delegates stopped short, however, of requiring the trustees to notify HEW at this time of its opposition to the anticipated regulations, which are currently being revised by HEW.

Strong objection to the use of any system of universal identification, including the Social Security number, for physicians and patients was made.

The AMA affirmed its opposition to any governmental mandate for examination of nursing home patients at arbitrarily predetermined intervals of time.

The AMA reaffirmed established policy that "statutory definition of death is neither desirable or necessary; death shall be determined by the clinical judgment of the physicians using the necessary available and currently accepted criteria."

The house also encouraged state medical associations to give appropriate assistance to physicians involved in countersuits to non-meritorious medical liability suits.

The delegates also approved a lengthy resolution urging JCAH to prevent hospitals from setting up rules that put authority for private patients in the hands of housestaff over the attending physician. The resolution, introduced by the New York delegation, was in response to charges by New York physicians that some hospitals were forcing attending physicians to turn over authority for writing treatment orders for private patients to housestaff.

The new president of the American Medical Association, Dr. Richard E. Palmer, warned that the federal government is the biggest threat to the medical profession, and urged all physicians to unite in the AMA for their own protection.

The government "has made itself a rigid custodian of the people's common hopes and horizons," charged the Alexandria, Va., physician at his inaugural ceremony June 30 in Dallas.

But the federal government, having made itself the "chief arbiter of what is desirable," by now has shown that "it is far less adept in realizing possibilities, however, than in stimulating desires," Dr. Palmer said.

"Some group has to be blamed and disciplined for the embarrassing gap, and in medical care, that group is the givers if care."

He counted off failures and mistakes in federal and congressional actions regarding medicine, including the ill-fated utilization review regulations, the Health Planning and Resources Development Act, the House report on "unnecessary surgery," and the Federal Trade Commission antitrust charges against the AMA.

"Instead of settling for a reasonable adjustment to medical realities," he said, "government is becoming steadily more dogmatic."

The only way to combat federal intrusion into medicine, he said, was for physicians to unite behind the AMA in its efforts on behalf of the profession and of quality medical care.

JAMES A. HARSHMAN, M.D., JOHN O. BUTLER, M.D., MALCOLM O. SCAMAHORN, M.D., PATRICK J. V. CORCORAN, M.D., PETER R. PETRICH, M.D.—Delegates.

GEORGE LUKEMEYER, M.D., ROSS L. EGGER, M.D., EVERETT BICKERS, M.D., THOMAS C. TYRRELL, M.D., MARVIN E. PRIDDY, M.D.—Alternates.

Address of AMA Trustee Lowell H. Steen, M.D.

ACTION: Referred to the Board of Trustees to (1) Investigate the feasibility of unified membership in the AMA of all members of the ISMA and (2) Report to the House at its next annual meeting.

It is a great pleasure to report to you about the activities of the American Medical Association. I have the pleasure and honor of serving you on the American Medical Association Board of Trustees because of your confidence and support.

I bring greetings from your officers and trustees of the American Medical Association.

Many of you know that in November 1974 the American Medical Association was virtually insolvent. The Board of Trustees had to borrow money to keep the ship afloat. There was a vigorous tightening of belts. The House of Delegates approved an assessment of $60.00 which, to date, approximately 75% of the AMA members in Indiana have paid. Likewise, a dues increase was approved, and by the action of Dr. Sammons and his staff in Chicago, by careful scrutiny of the Finance Committee of the Board, and by judicious elimination of non-critical programs, we have reached the point where today the American Medical Association is in sound financial condition.

In order to meet our budgetary goals of 1976, the Finance Committee predicted that 144,000 members were necessary to achieve our goals without a futher cutback in programs. As of the last Board meeting on the 10th of September, the full dues-paying membership exceeded the minimal level of 144,000, and, based upon projections, by the end of the year we should have a full dues-paying membership of 150,000 or more.

I am sad to report that, as of the last accounting, the AMA membership in Indiana is down 9% compared to this time last year. We have a large reservoir of physicians who are eligible for membership in the American Medical Association who are not members. It should be the duty of each and every member of this House to bend every effort to solicit membership of every eligible physician in your county.

The American Medical Association does represent all physicians, and its officers are indeed sensitive to what the practicing physicians of the United States want us to do for them. It is my hope that, since only part of the physician population now supports the activities of the American Medical Association with their efforts and their dollars and their membership, Indiana will join the four other states who have unified membership—Illinois, Arizona, Wisconsin and Hawaii—by having introduced into this House a resolution requiring unified membership for all physicians in Indiana. I would hope that this will be debated far and wide throughout the state of Indiana, and ultimately will be adopted by this House of Delegates at a session in the not too far distant future.

I shall briefly recount some of our recent valuable activities. Every physician in this country benefits from these activities, and it is my personal belief that every physician who benefits from them should share in paying for the cost inherent in obtaining these benefits. There should be no free lunch.

In reporting to you, the logical place to begin is with some of the major concerns that face us, and a recounting of what the federation is doing about these problems. Uppermost in all of our minds is still the recurring professional liability crisis. We believe, of course, in Indiana we have the ideal solution to this problem—an almost perfect solution! It is due to the efforts of the members and the leadership of this Association that this landmark legislation was passed.

A few weeks ago the American Medical Association formally established The American Medical Assurance Company, or AM-A-Co, which provides *re-insurance* for those physician-operated programs which may wish to use it. The AMA has deposited $2,000,000 in a reserve fund in a Chicago bank to fund this company.

There are external threats to American medicine, including the torrent of new federal programs, proposals, rules and regulations. The legislative staff reviews over 3,500 pieces of legislation a year. There is hardly a day goes by but what our Association presents testimony before the Congress or before subcommittees of the Congress on issues that have serious implications for every practicing physician in the United States.

To dampen this flood of new government, the AMA has been obliged to seek legal relief in the Federal Courthouse, and, as a consequence, there are landmark federal court suits against the Hospital Utilization Review Regulations, and, I would add, today there are still no utilization review rules on the book. They are still *proposed* and they have *not been published;* and I reiterate *if* at such time those rules are published and they are in any measure offensive to us, we will again seek relief in the federal courts, since, as you will remember, when we agreed to dismissal of our case, it was dismissed *without prejudice*. This means that at any time in the future we can again seek relief in court. I pledge to you that I will vote to seek relief when, if and as these regulations become a threat.

The Maximal Allowable Drug Cost, or MAC regulations, were the subject of another suit, as was the Health Planning Act of 1974. We not only entered that suit amicus curiae, but entered it with the State of North Carolina as a co-litigant. We opposed the MAC rules because, in addition to their unwarranted assumption of bio-equivalents, they violate the physician's right and responsibility to prescribe the drugs he determines are best for the patient. And because they violate the patient's right to receive these drugs.

Almost weekly we must zero in on the regulatory process itself—that method of legislation by regulation that has become so pervasive in our government today. The AMA has supported legislation in the recent Congress which will, in essence, keep federal regulations from taking effect so hastily and capriciously and loosely as they do now.

The physician who says he obtains no benefits from the AMA certainly does not realize that the American Medical Association was instrumental in preventing the Medicare roll-back in reimbursement over a year ago. The dollar reductions that would have resulted to each physician would more than pay his dues at the current level in most instances in less than one week.

Not only have we been successful in our argument in the courtroom, but in the conference room as well. And I refer, of course, to the agreement by the House-Senate confreres a few weeks ago, to eliminate objectionable provisions of the Health Manpower legislation which stripped from the final version of the bill federal standards for medical licensure and relicensure, federal controls on the numbers and locations of residencies, requirements for mandated service for medical students, and for payback of federal capitation payments, and at least some capitation restrictions on medical schools.

To provide state medical associations with a capability of responding in a militant fashion to governmental influences, we have recently established a Department of Negotiations. This department has to date held a number of extremely successful working seminars that are designed to teach physicians the art of negotiation. This will become more important to us in the near future.

To standardize medical care, to break it down into so much care at so much cost per patient, only results in standardization of physicians and standardization of patients. The very heart of our pro-

fessionalism, in fact, is maximum clinical freedom for the individual patient, because it is each of us who must make the medical system respond to the needs of each of our patients. This explains why the doctor-patient relationship is the keystone of high quality medicine. It is why our profession and why the AMA have always been, now are, and will continue to be, so protective of any *unreasonable* intrusion on that relationship, particularly by government. Unfortunately, far too many physicians have an almost incredible lack of knowledge and understanding of our federation's activities. I emphasize the need for knowledge and understanding. We must not only apprise physicians of what we are doing, but we must make them understand why we are doing it.

Some physicians counter, when apprised of these benefits of AMA involvement, that they don't need this kind of help, that these matters are of little consequence to them. So, we must enumerate the benefits that can be held in our hand and counted, such as our journals, our insurance programs, the retirement provision under the Keogh Plan. Such answers are important!

Thirty-four percent of the American Medical Association budget is spent on programs designed to educate and inform the physician. Approximately 40% of the budget is concerned with our publication effort, and 18% is budgeted for educational programs, the accreditation of schools, residency training programs and continuing medical education programs.

Some people do not agree with the stance the American Medical Association has taken on some issue or another, and certainly all of us at times disagree with some action that has been taken collectively by the American Medical Association. We cannot expect that every plan or program will be exactly what each of us desires, expects or thinks is wise. But let us not forget that our profession has heavy public responsibilities, and they have long been a part of our medical tradition. So, here again, every one of us must be willing to help bear the burden, because, as we shape the climate in which we practice medicine, we are also helping to shape our society and our future.

To maintain a favorable medical climate in America, then to fulfill our responsibilities to the public as well as to our patients, will require a strong and dedicated federation. And this, in turn, requires physicians who understand all the dimensions of good medicine, and who are willing to contribute to those good ends through our federation. It is my sincere wish that this message would reach every physician in the nation, and I hope you will help me by taking this message back to all of the physicians in your community.

Reports of Committees

Executive Committee

ACTION: Filed.

The Executive Committee met immediately following the organizational meeting of the Board of Trustees of ISMA on the final day of the 1975 Convention at French Lick and elected Dr. Joe Dukes chairman.

A number of meeting were held during the year, both prior to meetings of the Board and between Board meetings.

The extent of items brought to the attention of the Committee and subsequent actions make it impractical to relate totally the business undertaken.

The committee, however, did deal with the operation of the Headquarters Office, clarified many policies on internal operation, such as utilization of legal counsel, arranged and participated in the annual visitation with Indiana congressmen in Washington, reviewed proposed expenditures by the Convention Arrangements Committee, made budgetary adjustments periodically, heard reports from commissions seeking funds for various projects, reviewed requests for mailing lists and served as a review body at the request of medical societies in several instances. These are broad generalizations on the Committee's activities.

The business of the Association increasingly requires more activity by the Executive Committee. Many of the Comittee's actions are reflected in the accounts of the Board of Trustees to which items were referred.

The actions of the Executive Committee, although not circulated to the members, are always available to the membership upon request.

Medical Defense Activities

1. Malpractice Cases. A year ago at the time of this report, August 1975, the following six cases were pending before the committee:

Case 313—Suit filed Sept. 5, 1967. Pending. (Expense to date $600.00).

Case 314—Suit filed approximately July 6, 1970. Pending.

Case 316—Suit filed July 2, 1970. Pending.

Case 321—Suit filed May 30, 1974. Pending.

Case 323—Suit filed Aug. 30, 1974. Closed. (Expense $720.00)

Case 324—Suit filed Feb. 3, 1975. Pending.

Since Aug. 1, 1975 to Aug. 1, 1976, no new cases have been filed.

2. Medical Defense Fund Statement from July 1, 1975, to June 30, 1976:

Bank Balance, July 1, 1975	$30,406.44
Receipts	4,988.89
Total cash and receipts	$35,395.33
U. S. Treasury Bonds	25,060.21
Due from General Fund	1,313.64

The Journal

Listed below is a comparative report of *The Journal* operations over the past several years and the first six months of 1976, as follows:

The first table shows the number of journal pages for the past five years (includes inserts).

Year	Reading	% Reading	Adv. Pages	% Adv. Pages	Total Pages	Av. No. Pages Per Issue
1971	970	70	426	30	1396	116
1972	933	69	433	31	1366	113
1973	877	73	321	27	1198	100
1974	870	69	282	31	1176	98
1975	792	71	318	29	1110	93

The table below show the total printing costs of *The Journal:*

Year	Total Printing Costs	No. of Pages (Inserts Excluded)
1972	41,789.70	1106
1973	42,642.43	1028
1974	50,895.65	1176
1975	52,742.30	1110
1976 (6 mos.)	23,360.68	436

A comparison of advertising revenues for the first six months of the last four years, with a like figure for 1976, is as follows:

Year (Jan.-June)	Sold by State Medical Journal Adv. Bureau	Sold direct By Journal	Total
1972	17,869.96	1,622.60	19,492.56
1973	10,938.94	2,134.95	13,073.89
1974	10,280.92	3,151.00	13,431.92
1975	9,250.86	3,763.16	13,014.02
1976	8,512.17	4,360.00	12,872.17

JOE DUKES, M.D., *Chairman:* RICHARD G. INGRAM, M.D., VINCENT J. SANTARE, M.D., JOHN W. BEELER, M.D., ELI GOODMAN,

M.D., GILBERT M. WILHELMUS, M.D., ARVINE G. POPPLEWELL, M.D.

Future Planning

ACTION: Filed.

The Future Planning Committee has held three meetings, Feb. 8, Mar. 28, and May 19, 1976, all at Association Headquarters.

The committee embarked on a program to project what the ISMA should be doing the forthcoming year and in 5 and possibly 10 years. This was done with the realization that plans and programs may be subject to change, depending on current events. Since the committee was small, the majority of the membership was present at all meetings, allowing for a good and free discussion by all present.

In the initial meetings the committee discussed: (1) The provision of services by the ISMA which are attractive to members and constitute a positive program by the ISMA. (2) The fact that the Association will soon need to be dealing with PSRO, HSAs, and other governmental regulations which are appearing with increasing frequency. (3) The need for continuing and concentrated promotion and publicity to the membership concerning services provided by the ISMA. (4) The possibility of using *The Journal* as a communication vehicle with the thought of possibly including more emphasis on socioeconomic issues and practice management articles. (5) On a long range basis, consider ways of developing an alternate source of income for the ISMA. An example of this may be the possibility of providing medical management resources for physicians. (6) Consider providing each member with a ready reference guide on policies patterened after the AMA quick-reference guide. (7) The possibility of developing a computer capability by the ISMA for the collection and storage of appropriate data.

With these thoughts, the committee requested and obtained the AMA's planning process as reported in "An Overview of the AMA Planning System." This was carefully reviewed and the plan was sent to the ISMA Board of Trustees for its consideration.

It was thought by all committee members that before plans could be formulated: (1) All committee and commission chairmen be polled concerning their thoughts and suggestions regarding the direction the ISMA should be taking, each in regard to his committee or commission, (2) Member and possibly nonmember physicians be polled, and (3) A feasibility study be conducted for the ISMA concerning computer applications.

A number of the committee and commission chairmen answered the poll. These answers will be sent to the Board of Trustees for consideration and action.

The previous membership questionnaire has been reviewed and a new one developed. The questionnaire will be presented to the Executive Committee for their consideration and review with the committee's recommendation that funds be approved to carry out the membership poll.

The ISMA is the major spokesman for all the physicians in Indiana. In order to carry out this function, the committee thought that some form of data bank and computer facilities were needed to obtain accurate answers to questions promptly. A well devised program with the proper data will allow the Board of the ISMA to obtain answers to questions concerning membership, physician distribution, etc. thereby facilitating knowledgeable decisions. It was also agreed that, if at all possible, the system be developed in such a manner that it will be self-supporting and may *possibly generate* funds for the ISMA. The protocol, concepts of a feasibility study, and cost estimates for such a study will be presented to the Board for consideration and action. It is the recommendation of the committee that funds be granted to undertake the feasibility study.

STANLEY M. CHERNISH, M.D.
Chairman

LOWELL H. STEEN, M.D., PETER R. PETRICH, M.D., E. HENRY LAMKIN, JR., M.D., WILBERT McINTOSH, M.D., JACK SHANKLIN, M.D., JOHN O. BUTLER, M.D., GARY WRIGHT (STUDENT), RANDY LEE, M.D. (RESIDENT), GEORGE ARONOFF, M.D. (INTERN).

Grievance Committee

ACTION: Filed.

The Grievance Committee had but one meeting within the past year and all cases pending over the past three years were brought to its attention. In several, all of the necessary action was completed and the cases were considered closed. In two cases, complaints regarding fees and reimbursements were referred to Blue Shield; their prompt action was forthcoming, the complainants were notified and both cases were closed. Only three cases of a minor nature are pending and as soon as the local medical societies have notified us of their action we hope we can close these cases also.

As in the past, we will continue to refer complaints to the local medical societies and, when appropriate, to the insurance company underwriter. With this policy, we find it unnecessary to hold numerous meetings and shall depend on the continuing cooperation and understanding of the membership.

THOMAS C. TYRRELL, M.D.
Chairman

RICHARD S. BLOOMER, M.D., EUGENE S. RIFNER, M.D., WARREN N. McCLURE, M.D. GEORGE M. LEWIS, M.D.

Medical-Legal Review

ACTION: Filed.

The Medical-Legal Review Committee handled a minimum of routine problems during the year without having to call a formal meeting. The committee activities were once again curtailed because of the Ad Hoc Committee which has been handling the medical liability area, which was one of the major functions of this committee.

Our association is fortunate to have this Ad Hoc Committee which has worked very diligently to provide us with P.L. 146 and the amendments passed during the last session of the General Assembly which helped strengthen the constitutionality and understandability of this law.

The Medical-Legal Review Committee is anxious to help the Ad Hoc Committee in whatever way it can.

JOHN W. BEELER, M.D.
Chairman

WILLIAM R. CAST, M.D., PAUL F. MULLER, M.D., JAMES J. STEWART (ATTORNEY), GEOFFREY SEGAR (ATTORNEY), F. BOYD HOVDE (ATTORNEY).

Ad Hoc Committee on Improvement of Medical and Health Care in Jails

ACTION: Filed.

Your Committee is pleased to report on the status of the Jail Project, as of July 15, 1976, and request the attention and interest of the members of the Indiana State Medical Association in the future of the project.

In late 1975, the American Medical Association received a grant from the LEAA Criminal Justice Agency to carry out a pilot program. The purpose was to involve organized medicine on all levels in the establishment of the nation's detention centers, correctional institutions, with the assistance of local officials and other appropriate disciplines and professions; to develop nationally applicable medical guidelines for these institutions at the level which will insure an acceptable standard of medical care; and to establish a health and medical certification program to serve the nation's correction system.

Indiana was selected as one of the six states to carry out a pilot program. The Indiana Jail Project is sponsored by the Indiana State Medical Association, but with the close cooperation of the Indiana Lawyers' Commission, an arm of the Indiana Bar Association, and with the

help of many different groups in the state. Since January 1976 much work has gone into devising a program which will, first, evaluate the present jails' conditions, and, specifically, the health care being provided, and then move towards establishing certain standards which are reasonable and practical and can lead to an ongoing program whereby all of the jails in our state may provide adequate health services and be eligible for a national certification program.

Aside from the humanitarian aspect of this project, there is an important practical consideration which has dictated urgent implementation of this type program. A quote from a local newspaper in April 1976 illustrates this, "Indiana's antiquated prison system is threatened with a costly United States Justice Department Civil Rights lawsuit unless steps are taken to correct overcrowded conditions and inadequate medical services." Some time ago, a federal mandate was given to Lake County relative to jail services. More recently, the Federal District Court for the Southern District directed that the Marion County Jail should make specific changes, including specific directions relative to medical examinations, dental care and improved health situations.

The Indiana Committee for implementing this AMA jail program selected seven counties to form the basis for its pilot studies. These counties are Marion, Lake, Greene, Monroe, Morgan, Owen and Brown Counties. The latter five counties were selected because of their contiguous nature and with the specific idea of seeing what type program might be devised which would be practical and helpful for the smaller counties in our state. Mr. Newton Goudy, a former executive secretary of the Indiana Bar Association, was selected to be the project director for Indiana. Dr. Dwight Schuster was named the medical director and Judge Fred Rakestraw, the legal director.

The first part of the project was to gather baseline data. All of the seven counties involved have been most cooperative, and this aspect of the project has now been completed and the results are being analyzed. The next general object was to develop standards for medical care and health services in jails, and this is rapidly approaching completion. The next part of the project will be the development of an inmate physical profile. This program will consist of a medical history, physical examination and brief laboratory study on all of the inmates in small jails and a percentage of the inmates in the two larger jails, the latter to be at least 50 inmates. Making this study will form another part of our baseline data and enable us to evaluate changes and improvements in the system in subsequent years.

With the evaluation of the results obtained from the baseline data and the conferences held by representatives of the six pilot states, we will be in a position to make suggestions relative to improvements in the respective jails in the pilot program. The second and third year portions of this project will entail the expansion of the program to all the jails and the development of some means of an ongoing certification program. The response from the various sheriffs and jail officials has been most encouraging and, with the continued support of the general community and, particularly, the medical community and county officials, this program should move on to a successful completion and be of great value to all concerned.

As the chairman of the ISMA Ad Hoc Committee on Medical and Health Care in Correctional Institutions and as Medical Director of the ISMA Indiana Jail Project, I wish to express my appreciation and that of the members of the committee for the support and encouragement we have had from the officers of the Association, the limited number of ISMA members who have known about and who have been invited to participate in our work, and to Executive Director Donald Foy and his staff at the ISMA office for their valued help.

DWIGHT W. SCHUSTER, M.D.
Chairman

Reports of Commissions

Constitution and Bylaws

ACTION: Approved the report of the Commission on Constitution and Bylaws as amended with the additions and deletions accommodated by renumbering and relettering of appropriate sections, to lay on the table until the House of Delegates' meeting in 1977.

The Commission on Constitution and Bylaws met several times during the year and will present to the House of Delegates of the Association in October 1976, a revised Constitution and Bylaws.

The Commission, during its study of the Constitution and Bylaws, discovered much duplication of material. This new approach streamlines the Constitution, eliminates the duplications and incorporates other material currently contained in the Constitution into the Bylaws and simplifies understanding and readability of the document.

The Constitution has been printed twice in The Journal of ISMA preceding the meeting of the House, and the Bylaws will be presented to the House in October. Both documents will be contained in House of Delegates packets at the time of the annual meeting.

LESTER H. HOYT, M.D.
Chairman

THOMAS J. CORRAO, M.D., IVAN T. LINDGREN, M.D., JOHN E. FREED, M.D., C. G. CLARKSON, M.D., JOHN M. RECORDS, M.D., WALLACE A. SCEA, M.D., WILLIAM J. MILLER, M.D., FRANK M. STURDEVANT, M.D., ROBERT M. BROWN, M.D., JOHN B. GUTTMAN, M.D., MALCOLM WREGE, M.D. (deceased), GLEN WARD LEE, M.D., LLOYD L. HILL, M.D., WILLIAM R. CLARK, SR., M.D.

Admendments to Constitution and Bylaws

Constitution

ARTICLE I—TITLE AND DEFINITION

The name of this organization is the Indiana State Medical Association. It is the federacy of Indiana county medical societies.

ARTICLE II—PURPOSES

The purposes of this Association shall be to federate and bring into one compact organization the medical profession of the state of Indiana, and to unite with similar societies of other states to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education; to promote friendly relations among physicians; to protect its members against imposition; and to enlighten and direct public opinion in regard to the great problems of medical care and public health so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

ARTICLE III—COMPONENT SOCIETIES

Component societies are those county and district medical societies contained within the state of Indiana, and who hold charters from this Association.

ARTICLE IV—MEMBERS

The Indiana State Medical Association is composed of individual members of county medical societies and others as shall be provided in the Bylaws.

ARTICLE V—HOUSE OF DELEGATES

The legislative and policy-making body of the Association is the House of Delegates composed of elected representatives and others as provided in the Bylaws. The House of Delegates shall transact all business of the Association not otherwise specifically provided for in the Constitution and Bylaws and shall elect the general officers, except trustees, as otherwise provided in the Bylaws.

ARTICLE VI—OFFICERS

The general officers of the Association shall be a president, president-elect, immediate past president, [executive director,] treasurer, assistant treasurer, speaker, vice speaker, and the trustees. Their qualifications and terms of office shall be provided in the Bylaws.

ARTICLE VII—TRUSTEES

The Board of Trustees is composed of trustees and alternate trustees elected by the component district medical societies, and the president, the president-elect, treasurer, immediate past president, the assistant treasurer, with power to vote only in the absence of the treasurer, and the speaker and vice speaker without power to vote and the executive director without power to vote. The alternate trustees have power to vote only in the absence of the trustee.

ARTICLE VIII—THE CONVENTION

The House of Delegates and the general scientific program shall be convened annually and at such other times as deemed necessary or as provided in the Bylaws, in cities recommended by the Board of Trustees and approved by the House of Delegates.

ARTICLE IX—FUNDS, DUES AND ASSESSMENTS

Funds may be raised by annual dues or by assessment of the active members on recommendation of the Board of Trustees or any other manner approved by the House of Delegates. Any change in dues or any assessment must be approved by the House of Delegates.

ARTICLE X—AMENDMENTS

The House of Delegates may amend this Constitution at any convention provided the proposed amendment shall have been introduced at the preceding annual convention and provided two-thirds of the voting members of the House of Delegates vote approval and provided that it shall have been published twice during the year in *The Journal* of the Association.

Bylaws

DIVISION ONE—MEMBERSHIP

CHAPTER I—QUALIFICATIONS, ELECTION AND RIGHTS

Section 1. *Regular Member.* The term "regular member" as used in these Bylaws shall include Active, Senior, Military Service Member, Public Health Service Member, Disabled Member, Medical Student Member, Interns and Residents, of component county medical societies who hold the degree of Doctor of Medicine or Bachelor

of Medicine, or who hold an unrestricted license to practice medicine and surgery. As to Interns and Residents they shall be serving in training programs approved by the Association, or if a Medical Student they shall be enrolled in a medical school approved by the Association. All regular members are entitled to exercise the rights of membership in their county and state association, including the right to vote and hold office, as determined by their respective county medical society and/or their state association.

A regular member who is a member in good standing of a component county society and who has paid to this Association his annual dues is a member in good standing of the Indiana State Medical Association, provided, however, that he is a citizen of the United States of America, or has filed his declaration of intention of becoming a citizen and his first citizenship papers are in full force and effect.

Section 2. *Special Member.* The term "special member" as used in these Bylaws, unless otherwise indicated, shall mean Associate Members and Honorary Members as defined in Section 3, Chapter I of the Bylaws of the Indiana State Medical Association. Special members shall not be entitled to vote or hold office in this association.

Section 3—Members by Category

A. *Active Members.* The active members of this Association shall be the members of the component county medical societies, and no county medical society shall grant active membership therein on a basis that does not include membership in the district medical society and in the Indiana State Medical Assocation.

[B. *Associate Members.* Members of the Indiana State Dental Association in good standing are, by virtue of their membership therein, made associate members of the Indiana State Medical Association.]

B. *Interns and Residents.* Interns and Residents who hold membership in the Indiana State Medical Association shall have all the rights and privileges of this Association.

C. *Senior Members.* Senior Members shall be eligible for Senior Membership on January 1 following their 70th birthday and they shall be physicians of the State of Indiana and who have held their membership in the Indiana State Medical Association for 20 years or more; or who have held membership in the Indiana State Medical Association or in some one or more other like state organization which is a component state organization of the American Medical Association, for a combined total of 20 years or more, and who, upon their application, have been certified to the Executive *Director* as eligible for such membership by the county societies of which they are members. It shall be the duty of the county medical society to verify, through the office or offices of any other state organization or organizations, the fact of membership therein when such membership is claimed as part compliance with the eligibility requirement of 20 years of membership.

D. *Honorary Members.* Honorary members shall consist of teachers, scientists and others who have rendered highly meritorious service to the profession of medicine, and of physicians and surgeons of distinction, upon whom the Association may, through vote of the House of Delegates, desire to confer such membership as a special honor.

Honorary members hereafter elected shall hold such membership as an honor and distinction and shall have the right to attend meetings of the Association. They shall have the privilege of participating in discussions but shall have no right to vote or to hold elective office. They shall not be required to pay membership dues in the State Association. Such honor may be conferred by the vote of the House of Delegates.

E. *Disabled Members.* Disabled members shall consist of physicians of the State of Indiana who are certified by a member physician to be permanently disabled and no longer able to practice medicine and who continue to reside in the State of Indiana. Proof of permanent disability shall be by notification to the Executive *Director* of the Association by the secretary of the county medical society in which such permanently disabled physician holds membership.

All such disabled members shall receive membership cards and THE JOURNAL of the Association without charge.

F. *Distinguished Members.* Active members who have fulfilled the American Medical Association's Physician Recognition Award requirements of 150 hours for three years of continuing medical education as a minimum shall be designated as Distinguished Members.

G. *Military Service Members and Public Health Service Members.* Any physician who is actively engaged in the military service or public health service shall be eligible for membership in the Association with payment of reduced dues; they shall receive THE JOURNAL.

H. [Retired] Members who have chosen voluntary *inactivity* [retirement] from the practice of medicine before the age of 70 shall only be required to pay membership dues in the amount of one half of full membership dues applicable at the time [of retirement.]

I. *Student Members. Medical students who attend an accredited medical school in Indiana.* [Students who hold active membership in the Indiana Chapter of the American Medical Student Association.]

Student members[hips] may be represented in the House of Delegates with [all the rights and privileges and] the power to vote. They shall be entitled to send one delegate or one alternate [who are members of the Indiana Chapter of the American Medical Student Association]. Student delegate and alternate are to receive THE JOURNAL of the State Association.

Section 4—Rights and Privileges of Members

A. Suspension or Revocation of License

No person whose license to practice medicine has been suspended or revoked or who is under sentence of suspension or expulsion from a component society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Association or of a component county society, nor shall he be permitted to take part in any of their proceedings until he has been relieved of such disability.

B. Attendance at Annual Convention

Each member in attendance at the Annual Convention shall register by indicating the component society of which he is a member. When his right to membership has been verified, by reference to the roster of his society, he shall receive a badge, which shall be evidence of his right to all the privileges of membership at that convention. No member shall take part in any of the proceedings of an Annual Convention until he has complied with the provisions of this section.

C. Rights and Privileges by Membership Category

Rights and Privileges of Members. Active members, intern and resident members, senior members, military service members, public health service members, disabled members, honorary members, student members and *inactive* [retired] members shall have the same rights and privileges except as follows:

(a) Senior members shall not be required to pay membership dues in the State Association.

(b) If senior members desire to receive THE JOURNAL of the State Association, they shall pay the

regular subscription price therefor.

(c) Senior members who desire the benefit of medical defense as provided by the Bylaws of this Association shall pay the amount stipulated in Section 1, Chapter XVI of the Bylaws for this coverage.

CHAPTER II—DUES, FUNDS AND ASSESSMENTS

Section 1—Dues

A. Income and Expenses

Funds for carrying on the activities of this Association shall be raised by the following means:

(a) Membership dues to be collected may be collected by the Indiana State Medical Association or by the component county societies. The amount of dues of each component society shall be fixed by the society itself; and the amount of dues for this Association shall be fixed from time to time by the House of Delegates.

(b) Voluntary contributions.

(c) Revenues derived from the Association's publications.

(d) Upon recommendation of the Board of Trustees or any other manner approved by the House of Delegates.

Funds may be appropriated by the House of Delegates to defray the expenses of the Association, for publications, and for such other purposes as will promote the welfare of the profession. All motions and resolutions appropriating funds must be referred to the Board for approval before final action is taken thereon.

B. Change in Dues Structure

The final vote on any issue calling for changes in dues or in dues structure shall be by roll call vote *of the House of Delegates.* Each member's vote shall be permanently recorded and no suspension of this rule will be allowed on the final vote on such an issue.

DIVISION TWO— ANNUAL CONVENTION ACTIVITIES

CHAPTER III—CONVENTION AND MEETINGS

Section 1—Annual Convention

The Association shall hold an Annual Convention during which there shall be held such general and section meetings as the Association through its duly constituted officers and committees may provide for.

Section 2—Selection of Site

The House of Delegates shall select the place five years in advance for holding the Annual Convention. The time for the convention shall be fixed by the Board, and the Board shall have the power also to change the place for holding the convention where conditions may create difficulties in holding a successful convention at the place designated by the House of Delegates.

Any of the component member county societies wishing to invite the Indiana State Medical Association to hold its annual meeting in its locality shall submit an invitation in writing at least five years in advance to the Board of Trustees. The Board of Trustees shall make an investigation of the facilities and in turn recommend the location to the annual meetings for concurrence by the House.

Section 3—Special Meetings

Special meetings of either the Association or the House of Delegates shall be called by the President upon receipt of a petition signed by thirty delegates or one hundred members. The signed petition shall contain the names of at least ten delegates or thirty-four members from each of at least three Board districts. Upon receipt by the President of such a petition, the President shall within thirty days thereafter issue a call for such special meeting at a time and place to be fixed by the President. The President, in specifying the time of such special meeting, shall fix the same as soon thereafter as reasonable and suitable arrangements can be made.

Section 4—General Meetings

General Meetings shall mean all meetings planned for attendance by all registered members, and shall include those meetings in which guests of registered members or the general public are also invited. The address of the President may be delivered in a General Meeting, and the programs of General Meetings shall be arranged by the Executive Committee except where scientific papers are included, in which event the scientific part of the program shall be arranged by the Commission on Convention Arrangements, with the sanction and approval of the officers.

Section 5—Appointment of Committees

The General or Section Meetings may recommend to the House of Delegates the appointment of committees or commissions for scientific investigation of special interest and importance to the profession and public.

Section 6—Scientific Papers

All scientific papers read before the Association or any of the sections shall become its property and shall not be published in any but the official publications of this Association, except by consent of the officers and the Editorial Board of this Association. Each such paper shall be deposited with the Executive *Director* when read.

Section 7—Appropriations

The Board *of Trustees* shall appropriate from the funds of the Association such an amount as in the discretion of the Board shall be reasonably needed for that purpose, and no commitments shall be made for expenses in excess of the amount appropriated for such Convention. The funds so appropriated shall, upon the approval of the Executive Committee, be expended at the direction of the Commission on Convention Arrangements appointed by the President for the Convention for which the appropriation is made. All money in excess of that expended for actual expenses incurred shall revert each year to the treasury of the Association.

CHAPTER IV—SPECIALTY SECTIONS

Section 1—Official Sections

During the Annual Convention the Association in addition to the general meetings may hold the following section meetings:

a. Surgical
b. Internal Medicine.
c. Eye, Ear, Nose, and Throat.
d. Anesthesia.
e. Family Physicians.
f. Obstetrics and Gynecology.
g. Preventive Medicine and Public Health.
h. Radiology.
i. Nervous and Mental Diseases.
j. Pathology and Forensic Medicine.
k. Pediatrics.
l. Directors of Medical Education.
m. Cutaneous Medicine.
n. College Health Physicians.
o. Interns and Residents.
p. Allergy.
q. Urology.
r. Orthopedic Surgery.
s. Emergency Medicine.
t. Any other sections that hereafter may be provided for by the House of Delegates.

Any other sections that hereafter may be provided for

by the House of Delegates. All proposed sections will be formed by properly constituted resolution which shall include the signatures of a minimum of 15 members or 25% of the members, whichever is greater, who are practicing that specialty in the state of Indiana.

Section 2—Officers

The officers of each section shall be a chairman, a vice-chairman, and a secretary, and they shall preside over the meetings of the sections and shall be responsible to the Committee on Scientific Work for the section speakers and papers.

Section 3—Officer Elections

The election of officers of the sections shall be the last order of business of the last meeting of the sections during the Annual Convention.

Section 4—Restriction on Meetings

No section meeting shall be allowed to conflict with a general meeting.

DIVISION THREE— BUSINESS AND LEGISLATION

CHAPTER V—HOUSE OF DELEGATES

Section 1—Composition

The House of Delegates shall be the legislative and policy-making body of the Association and shall consist of (1) Delegates, or their designated alternates, elected by the component county societies; (2) the Trustees, or their designated alternates, and (3) the ex-presidents of the Indiana State Medical Association. The delegate or their designated alternate delegate elected by their respective section shall also be a member but without power to vote. The following shall be *ex officio* members: The President, the President-Elect, the Executive *Director*, the Treasurer and Assistant Treasurer of this Association, the Speaker, the Vice Speaker and the delegates to the American Medical Association, all without power to vote, except the Speaker and Vice-Speaker who shall vote as set forth in Chapter VI, Section 3 (F) and (G) hereafter.

Section 2—Meetings

The House of Delegates may meet on the day before the date set for the beginning of the general registration of the attendance at the Annual Convention. It may adjourn from time to time as may be necessary to complete its business, provided that its hours shall conflict as little as possible with the general or section meetings. It shall meet on the last day of the Annual Convention for the election of officers for the ensuing year, and for the completion of any business previously introduced. The order of business shall be arranged as a separate section of the program. Nominations for officers of the Association may be made at any meeting of the House of Delegates.

Section 3—House Admission

All sessions of the House of Delegates shall be open to all members in good standing of this Association for observation.

Section 4—Delegate Apportionment

Each component county society shall be entitled to send to the House of Delegates each year one delegate for every fifty members and one for each major fraction thereof; but, irrespective of the number of members, each component society which has made its annual report and paid its assessments, as provided in this Constitution and Bylaws, shall be entitled to one delegate, except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county. [One delegate and one alternate shall be selected by the Indiana Chapter of the American Medical Student Association.] The student delegate shall be seated with full power to vote. In the absence of the student delegate, the alternate shall be seated with full power to vote.

The number of delegates to which each component society is entitled shall be based upon the number of members on record in the office of the Executive Director in good standing with current dues fully paid as of December 31 of the preceding year.

All sections listed in Chapter III, Section 1, of these Bylaws shall be entitled to send to the House of Delegates each year one delegate or one alternate delegate without the power to vote.

The names of duly elected delegates and alternates from each component society shall be sent to the Executive *Director* of this Association on or before February 1, prior to the Annual Convention at which such delegates are to serve. No one shall be entitled to a seat in the House of Delegates unless his credential card as a delegate or alternate, properly signed by the secretary of his county medical society, executive secretary or executive director of the larger societies, is presented to the Committee on Credentials at the time of the Annual Convention.

Section 5—Quorum

Fifty (50) delegates shall constitute a quorum.

Section 6—Responsibilities

A. Delegates to American Medical Association

The House of Delegates shall: elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

B. Organizing Districts and Sections

The House of Delegates may provide for a division of the scientific work of the Association into appropriate sections; and for the organization of such Trustee District Societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies. Trustee districts shall be defined by the House of Delegates.

The House shall divide the state into Trustee districts, specifying what counties each district shall include, and when the best interests of the Association and profession will be promoted thereby, organize in each district a medical society, and all members of component county societies, and no others, shall be members of such district societies.

C. Authority to Appoint Special Committees

The House shall have authority to appoint committees for special purposes from among members of the Association who need not be members of the House of Delegates. Such committees shall report to the House of Delegates, and the members of such committees may be present and participate in the debate on their reports.

Section 7—Resolutions and Proposals

The House of Delegates shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective.

Proposals calling for appropriations of funds by the House of Delegates shall be accompanied by a fiscal note and shall be submitted to the Executive Committee and the Board for review, presentation and recommendation for final action of the House. No proposal calling for appropriations shall be considered if not accompanied by a fiscal note.

All resolutions to be presented to the House of Delegates for action shall be prepared and mailed to the Executive *Director* of the Association so that he will receive them not later than 45 days prior to the meeting

of the House of Delegates to which the resolutions will be presented for action.

Provided, that where a resolution has been first submitted to the Committee on Rules and Order of Business together with a written statement setting forth the reasons why said resolution was not mailed to the Executive *Director* more than 45 days prior to the meeting of the House of Delegates and also setting forth in said written statement the reasons why said resolution is of such an emergency nature that it cannot wait until the next meeting of the House, and that said Committee on Rules and Order of Business has approved said resolution for submission to the House, and that each delegate shall be furnished a copy before the next meeting of the House, then this subsection of the By-laws may be suspended with respect to said resolution upon a two-thirds vote of the House of Delegates.

Section 8—Reference Committees and Committee on Rules and Order of Business

A. Reference Committees

Immediately after the organization of the House of Delegates at each Annual Convention, the President shall announce the membership of the reference committees to serve during the convention for which they are appointed. Appointments to these reference committees shall be made by the Speaker with the assistance of the President. The chairman of each committee shall also be appointed by the Speaker with the assistance of the President and they shall also appoint such additional House committees as the House may approve. All committees hereunder shall serve only during the convention at which they are appointed. Appointments shall be made in time for them to be published in THE JOURNAL and the Handbook prior to such Annual Convention.

The Speaker with the assistance of the President shall have the power to appoint substitutes from among the members present for absent appointees.

Each committee shall consist of at least five members, unless otherwise provided. To these committees shall be referred all reports, resolutions, measures and propositions presented to the House of Delegates, except matters as properly come before the Board, and the recommendations of these committees shall be submitted to the next meeting of the House of Delegates for acceptance in the original or modified form or for rejection.

B. Responsibilities of Reference Committees

Four or more Reference Committees designated by numerals are hereby constituted to which all matters shall be referred, at least one of which shall be organized for the sole purpose of studying the addresses of the president; president-elect; report of the Executive *Director;* and chairman of the Board of Trustees. This committee shall be mandated to translate recommendations made by these officers through resolutions for presentation to the House.

Where a report, resolution, measure, or proposition deals with more than one subject matter, reference thereof may, in the discretion of the [President] *Speaker of the House,* be made (a) to as many reference committees as are necessary to cover all subjects included therein; or (b) to only one reference committee which the [President] *Speaker* deems has within the scope of its reference the most important part of the matter referred.

No report of any reference committee shall be rejected on the ground that it covers something not included in the matters which such committee was created to consider.

C. Time and Place of Meetings

The time and place of meetings of all reference committees shall be publicly posted, and all meetings of all reference committees shall be open to all members of the Association.

Officers and chairmen of all committees whose reports are referred to reference committee shall have the right to appear and be heard before the respective committee to which such references are made, in regard to their reports.

D. Committee on Rules and Order of Business

The Committee on Rules and Order of Business shall be composed of the chairmen of the various Reference Committees appointed by the Speaker.

Section 9—Election of Officers

The officers of this Association with the exception of the Executive *Director* shall be elected by the House of Delegates as the first order of business at the final meeting of the House of Delegates, and no person shall be elected to any such office who has not been an active member of the Association for the preceding two years.

The election of officers shall be the first order of business of the House of Delegates after the reading of the minutes on the last day of the Annual Convention.

The officers, except [the Trustees and] the Executive *Director* [whose election has been provided for elsewhere herein,] shall be elected annually. All officers shall serve until their successors are elected and installed.

A. Method of Election

All elections shall be by ballot, and a majority of the votes cast shall be necessary to elect. In case no nominee receives a majority on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken.

B. Terms

The President, President-elect, Speaker, Vice-speaker, Treasurer and Assistant Treasurer shall serve from the termination of the annual meeting of the House of Delegates in which the President-elect, Treasurer and Assistant Treasurer are elected until the termination of the succeeding annual meeting of the House of Delegates.

C. Oath

The officers of the Association shall be installed by taking the following oath of office to be administered by the outgoing President of the Association at the final meeting of the House of Delegates:

I, , solemnly swear that I shall carry out to the best of my ability, the duties of the office of the Indiana State Medical Association to which I have been elected.

I shall strive constantly to maintain the ethics of the medical profession and to promote the public health and welfare. I shall dedicate myself and my office to improving the health standards of the American people and to do the task of bringing increasingly improved medical care within the reach of every citizen.

I shall uphold the Constitution of the United States of America and of the State of Indiana, the Constitution and Bylaws of the American Medical Association and the Constitution and Bylaws of the Indiana State Medical Association at all times.

I shall champion the cause of freedom in medical practice and freedom for all my fellow Americans. To these duties and obligations, I pledge myself, so help me God.

CHAPTER VI—OFFICERS

Section 1—Composition

The officers of this Association shall be a President, a President-Elect, the Immediate Past President, an Executive *Director,* a Treasurer, an Assistant Treasurer, a Speaker, a Vice-Speaker, each of whom shall be a member, except the Executive *Director,* who need not necessarily be either a physician or a member.

Section 2—Removal, Death, Resignation, Vacancy

Any officer may be removed from office after a hearing before the Board, on thirty days' notice, on charges in writing, upon a vote of three-fourths of the members of the Board.

In the event of the death, resignation, removal, or disability of the President, the President-Elect shall succeed to the presidency. In the event of the death, resignation, removal, or disability of both the President and the President-Elect, the Chairman of the Board shall become President Pro Tem and shall perform the duties and obligations as set forth in Section 3 of this chapter. As President Pro Tem the Chairman of the Board shall, within a period of sixty days, call a special session of the members of the House of Delegates for the purpose of electing members to fill these vacancies, who shall serve until the next regular meeting of the House of Delegates, at which time both a President and a President-Elect shall be elected, both of whom shall take office immediately upon their election.

The Board shall fill a vacancy in the office of Treasurer or Assistant Treasurer by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

Section 3—Duties

A. President

The President, or a member designated by him shall preside at all general meetings of the Association. The President shall appoint all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged by the Executive Committee, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the state during his term of office, and as far as practicable, shall visit by appointment the various sections of the state and assist the Trustees in building up the county societies and in making their work more practical and useful.

B. President-elect

The President-elect's term of office shall be for one year, at the completion of which he succeeds to the presidency. While President-elect, he shall assist the President in the discharge of his duties. *Ex officio, he shall be a member of all commissions and committees.*

C. Treasurer

The Treasurer shall give bond at the expense of the Association in such an amount as shall be required by the Board. He shall receive all bequests and donations to the Association and shall demand and receive all funds due the Association except accounts due THE JOURAL in the conduct of its business. The funds of the Association shall be deposited in a depository or depositories designated by the Executive Committee, and withdrawals from such funds shall be made on checks or drafts signed by the Treasurer and the chairman of the Board. He shall present to the House of Delegates annually a report of the receipts and expenditures, and the state of the funds in his hands, and shall subject his accounts to an annual audit by a Certified Public Accountant.

D. Assistant Treasurer

The Assistant Treasurer shall give bond at the expense of the Association in such amount as shall be required by the Board unless he is included in the coverage of a blanket or position bond. In case of death, or incapacity of the Treasurer, he shall succeed to all the duties and rights of the Treasurer until a new Treasurer be elected. In the absence of the Treasurer, he shall attend to the duties and rights of the Treasurer during such absence and he shall also perform such duties of the Treasurer as may be delegated and assigned to him by the Treasurer.

E. Executive Director

The Executive *Director* shall be the directing manager of the Association's headquarters and JOURNAL offices, and shall supervise the work of all salaried employees in the Association offices. Such supervision shall be subject to directives from the House of Delegates, the Board, the Executive Committee, and the President of the Association. He shall discharge the administrative functions of the Association not within the duties of other officers or of committees to perform. He shall assist, at their request, all officers and committees, and shall keep himself informed in regard to nonprofessional matters affecting the medical profession, for the purpose of keeping himself qualified to perform the services herein mentioned. He shall be responsible for the execution and carrying out of the policies of the Association and in that connection shall perform all specific tasks committed to him by the committees, the Board, and the officers of this Association. The amount of his salary shall be fixed by the Executive Committee on approval of the Board.

F. Speaker

The Speaker shall preside at all meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

He may address the House of Delegates at the opening meeting of all conventions, limiting his address to matters of conduct and procedure in the House. He is entitled to vote when the vote is by ballot. In all other cases, he shall have the right to vote only in case of a tie.

He shall be elected annually from the membership of the House. Ex officio, the Speaker shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Speaker and shall be provided at the expense of the Association.

G. Vice Speaker

The Vice Speaker of the House of Delegates shall officiate at meetings in the absence of the Speaker or at the request of the Speaker. The Vice Speaker shall be elected annually from the membership of the House. Ex officio, he shall be a member of all Commissions and Committees and the Board of Trustees of this Association without the power to vote. Training in parliamentary procedure shall be mandatory for the Vice Speaker and shall be provided at the expense of the Association. In the case of death, resignation or removal of the Speaker, the Vice-Speaker shall officiate during the unexpired term.

H. Expenses

The necessary expenses of the above officers incurred in the line of duty herein imposed shall be allowed for in the budget, but excepting the Executive *Director,* this shall not include the expenses of attending the Annual Convention.

CHAPTER VII—BOARD OF TRUSTEES

Section 1—Composition/Voting Power

The Board of Trustees shall consist of (1) the Trustees with power to vote and their duly elected alternates, each of the latter without power to vote except when the Trustee is not in attendance; and (2) ex officio, the President, President-Elect, Treasurer, Immediate Past President with power to vote, Assistant Treasurer without power to vote except in case the Treasurer is not in attendance, and the Speaker, [and] Vice-Speaker, and Executive *Director* without power to vote.

[Composition. The Board of Trustees shall consist of 22 members, 14 elected as provided in Section 3, Chapter VII, of the Bylaws, and the President, President-Elect, Treasurer and Immediate Past President, Assistant Treasurer, Speaker, Vice-Speaker and the Executive *Director*.]

Section 2—Authority

The Board shall be the executive body of the Association, with full power to fill vacancies or transact any business that emergencies or the welfare of the Association may require, and perform and exercise all of the rights and duties as specified in this chapter.

Section 3—Election

Election—Trustee and Alternate. The Trustees shall be elected by the respective district societies. If any district fails to meet and elect its Trustee(s) or Alternate Trustee(s) by the time of the expiration of the incumbent's term of office, the Executive *Director* of the Association shall cause a special meeting to be called by said district society for the purpose of such election.

Section 4—Meetings and Terms

The Board shall meet as follows: 1. The Board shall meet at least once each quarter of the calendar year, the time, date and location to be fixed by the Board. 2. On the day preceding the first day for the scientific meetings of the Annual Convention of the Association. 3. On the last day of the Annual Convention of the Association after the adjournment of the House of Delegates. 4. At such other times as necessity may require, subject to the call of the chairman, or on petition of three Trustees. It shall hold no meeting that will conflict with any meeting of the House of Delegates. Notice of each regular meeting shall be given at least ten days before such meeting.

Special meetings may be called at any time by the Chairman or at the request of seven members of the Board. Notice shall be given at least five days before each special meeting. The notice shall specify the general purpose of and business to be transacted at the meeting. [but other business may also be transacted.]

It shall elect a chairman, and a clerk, who, in the absence of the Executive *Director* of the Association, shall keep a record of its proceedings. It shall, through its chairman, make an annual report to the House of Delegates. It shall organize itself at the meeting following the final session of the House of Delegates by electing its chairman who shall serve for one year. The chairman of the Board shall be elected by secret ballot. The number of terms of the chairman shall be limited to not more than three in succession.

Terms of Trustees shall begin with the first meeting of the Board following the final session of the House of Delegates at the Annual Session.

The term of the elected Trustees shall be for three years and approximately one third of the number shall be elected annually. No Trustee shall be eligible to serve longer than two consecutive three-year terms.

Each Trustee district shall elect an Alternate Trustee whose term of office shall be for three years. The Alternate Trustee shall be elected in a year during which his Trustee is not elected.

Section 5—Vacancies

In the event of a vacancy occurring from any cause, except expiration of the term of office, in the office of any District Trustee, the duly elected Alternate Trustee from the same district shall succeed to the office of the Trustee in that District for the unexpired term of said Trustee. In the event vacancies occur in any Trustee District in the offices of both Trustee and Alternate Trustee, the vacancies shall be filled by an election by the members of the Association within the Trustee District in which the vacancies occur. A call for such elections shall be issued by the Executive *Director* of the State Association following a conference(s) with the officers of the District organization. The call shall state the time and place of holding the election and shall be sent registered mail to the County Secretary as filed in the State *Director's* Office of each component society within the District. Such call shall be mailed within ten days after the State *Director* has learned of the vacancies. The election may be held at a special or regular meeting at which business other than the election may be transacted. Such election shall be held within fifteen days after the *Director* of the State Association shall have mailed such call.

Section 6—Organization and Duties

A. Immediately following the conclusion of the annual convention, the Board shall organize by electing a Chairman *and a Clerk*. [Vice-Chairman, Secretary, and Committees necessary to its needs.]

The Board of Trustees at its organization meeting, by resolution adopted by a majority of the Trustees in office, may designate two Trustees or members *of the Association to complete the* Executive Committee. Members of the Committee shall serve until the next organization meeting of the Board and until their successors are elected and qualified. The Executive Committee shall have such powers and duties as may be defined from time to time by resolution of the Board of Trustees.

B. Quorum

Twelve members of the Board shall constitute a quorum.

C. Attendance at Meetings

If any elected Trustee fails, without reason acceptable to the Board, in any case one calendar year to attend a majority of the meetings of the Board, he shall thereby cease to be a Trustee, and the Executive *Director* shall thereupon take action in accordance with Section 5, Vacancies.

D. Meeting Notices

Notice is given if delivered in person, by telephone, mail or telegram. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail, addressed to a Trustee (and other persons entitled to notice) at his address then appearing on the records of the Association, with postage prepaid, and if given by telegraph, shall be deemed delivered when the telegram is delivered to the telegraph company.

Notice of any meeting and the object or business to be transacted at a meeting of the Board need not be given if waived in writing, or by telegraph, cable, or wireless before, during, or after such meeting. Attendance at any meeting shall constitute a waiver of notice of such meeting except where attendance is for the express pur-

pose of objecting to the transacting of any business because the meeting is not lawfully called or convened.

E. Business of Association

The Board shall perform all acts and transact all business for or on behalf of the Association and manage the property and conduct the affairs, work and activities of the Association, except as may be otherwise provided in the Constitution or the Bylaws. All resolutions and recommendations of the House of Delegates including the expenditure of funds passed by the House of Delegates, shall be referred to the Board of Trustees which shall determine if the resolution, recommendations or the expenditures are advisable. If it is decided that the resolution(s), recommendation(s), or the expenditure(s) is inadvisable, the Board shall report, at its earliest convenience, to the House of Delegates the reasons for its action.

F. Journal and Other Publications

The Board shall provide for the publication of and determine the editorial policies, in accordance with the policy enunciated by the House of Delegates, of (1) THE JOURNAL of the State Association, (2) publications as it may deem expedient, (3) a publication for public information and dissemination and (4) all proceedings, transactions and memoirs.

The Board shall provide for and superintend all publications of the Association, and shall appoint an editor and an editorial board, as it deems necessary, and fix the amount of their salaries. The proceedings of the Board for the year shall be reported to the House of Delegates at the Annual Convention and be published in the number of THE JOURNAL which immediately precedes the Annual Convention.

Appoint an editor or editors for all of the Association's publications.

G. Employ Executive

Employ the Executive *Director,* and fill any vacancy therein, who shall be the person to manage and direct the activities of the Association under the authority granted by the Board.

H. Financial Reports

(1) Have the accounts of the Association audited at least annually.

(2) Make proper financial reports concerning Association affairs to the House at its annual convention.

I. County Visitations, Expenses and Reports

Each Trustee shall be organizer, peacemaker, and censor for his district. He shall visit the counties in his district at least once a year for the purpose of organizing component societies where none exist; for inquiring into the condition of the profession, and for improving and increasing the zeal of the county societies and their members. He shall make an annual report of his work and of the condition of the profession of each county in his district, the same to be published in the number of THE JOURNAL which is issued immediately preceding the Annual Convention. The House of Delegates may take such action, if any, as it deems appropriate upon such reports. The necessary expenses incurred by such Trustee in the line of the duties herein imposed may be allowed by the Board on a properly itemized statement, but this shall not be construed to include his expense in attending the Annual Convention of the Association.

J. Organizing County Societies

The Board shall make careful inquiry into the condition of the profession of each county in the state and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist, and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly relations among physicians of the same locality and shall continue these efforts until every physician in every county of the state who can be made reputable has been brought under medical society influence.

In sparsely settled sections it shall have authority to organize the physicians of two or more counties into societies to be designated by hyphenating the names of two or more counties so as to distinguish them from district and other classes of societies; and these societies, when organized and chartered, shall be entitled to all the privileges and representation provided herein for county societies, until such counties may be organized separately.

K. Scientific Work

The Board shall, through its officers and otherwise, given diligent attention to and foster the scientific work and spirit of the Association, and shall study and strive constantly to make each Annual Convention a stepping stone to future ones of higher interest.

The Board shall encourage postgraduate and research work, as well as home study, and shall endeavor to have the results utilized and intelligently discussed in the county societies.

L. Interests of the Profession

The Board shall, in connection with the House of Delegates, consider and advise as to the interests of the profession and of the public in those important matters wherein it is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation and to diffuse popular information in relation thereto.

M. Charters

The Board shall, upon application, provide and issue charters to county societies organized to conform to the spirit of this Constitution and Bylaws.

N. Board of Censors

The Board shall be the Board of Censors of the Association. It shall consider all questions involving the rights and standings of members whether in relation to other members, to the component societies, or to this Association. All questions of an ethical nature brought before the House of Delegates or the General or Section Meetings shall be referred to the Board without discussion. It shall hear and decide all questions of discipline affecting the conduct of members of component societies on which an appeal is taken from the decision of an individual Trustee, and its decision in all such matters shall be final.

O. Election of At-Large Members to Executive Committee

The Board shall at its meeting following the close of the House of Delegates specify the duties and elect two members of the Association, at large, or of the Board, who, with the President, the President-elect, the Immediate Past President, the Treasurer, and the Chairman of the Board, shall constitute and be known as the Executive Committee. If such members of the Executive Committee be not members of the Board they shall not have the power to vote in the Board.

P. Duties of Alternate Trustee

The duties of the Alternate Trustee shall be:

(a) To represent the Trustee District when the regu-

larly elected Trustee is not in attendance.

(b) To vote only when the Trustee is not in attendance either in the House of Delegates or in the Board meetings where he represents the regularly elected Trustee.

CHAPTER VIII—THE EXECUTIVE COMMITTEE

Section 1—Composition

The Executive Committee, constituted as provided in Chapter VII (R) of these Bylaws, shall hold its first meeting immediately following the meeting of the Board held at the close of the last meeting of the House of Delegates in the Annual Convention, and shall organize by electing its chairman. Its secretary shall be the Executive *Director* of the Association. It shall meet with the Executive *Director* on the call of the chairman, or of any three members, to plan and execute such work as may be necessary for the welfare of the Association and the conduct of the Executive *Director's* office and such other duties as the Board may specify. It shall have all jurisdiction with respect to medical defense activities of the Association, and shall be governed by the rules it adopts concerning that activity and by the Bylaws of this Association. It shall make decisions for the Association, including matters pertaining to THE JOURNAL, during the intervals between the meetings of the Board, and shall report its actions to the Board.

Section 2—Budget Responsibility

It shall prepare a budget for the ensuing fiscal year; and all expenditures of the Association, except those otherwise provided for under the Constitution and Bylaws, shall be governed by the budget. No expense not provided for in the budget or otherwise under the Constitution and Bylaws shall be incurred by any officer, commission or committee. A committee, commission or officer may submit a request for funds to meet unusual expenses not included in the annual budget, and the Executive Committee shall have the power, by a two-thirds vote, to amend the budget to provide such funds.

Section 3—Investment of Surplus Funds

The investment of all surplus funds of this Association shall be under the direct control and management of the Executive Committee subject to instructions in regard thereto which may be given by the Board at its option. The Executive Committee shall have the right and is encouraged to obtain the advice and counsel of the investment departments of any bank or trust company of Indianapolis in regard to the discharge of the duties covered by this chapter of the Bylaws.

Section 4—Student Loans

The Executive Committee shall have the authority to make loans to medical students in accordance with the terms and conditions under which funds are made available for that purpose. Rules and regulations adopted shall be subject to the approval of the Board. The Executive Director shall have the duty and responsibility of keeping minutes of all transactions and shall file a copy of such minutes, as well as a copy of all papers pertaining to any application or loans, in the Headquarters Office of the Association.

Section 5—Vacancy

A vacancy on the Executive Committee shall be filled by an election by the Trustees at the next regular meeting of the Board following the occurrence of such vacancy.

CHAPTER IX—ORGANIZATION OF ACTIVITIES AND RESPONSIBILITIES

Section 1—Creation of Committees and Commissions

The organization of the Association, the performance of which is not provided elsewhere in the Constitution or Bylaws, and is not carried on in the meetings of the Board or of the House of Delegates, or by special committees created by the Executive Committee, the Board or the House of Delegates, may be performed by the following committees and commissions:

The Grievance Committee
The Future Planning Committee
The Medical Legal Committee

The Commissions are as follows:

COMMISSION ON MEDICAL SERVICES
This Commission encompasses the fields of:
Emergency Medical Services
Aging
Public Health
Governmental Medical Service Programs
Voluntary Health Agencies
Sports and Medicine
Medical Economics and Insurance

COMMISSION ON MEDICAL EDUCATION
This Commission encompasses the fields of:
Licensure
Accreditation
Education Program

COMMISSION ON LEGISLATION
This Commission encompasses the fields of:
State Legislation
Federal Legislation

COMMISSION ON CONSTITUTION AND BYLAWS

COMMISSION ON PUBLIC RELATIONS
This Commission encompasses the fields of:
Public Information
Special Activities
Interprofessional Relations

COMMISSION ON CONVENTION ARRANGEMENTS
This Commission encompasses the fields of:
Specialty Medicine

(The following Section 2 to be deleted and reference to student loans is provided for in Chapter IX, Section 4)

[Section 2—Student Loan Committee

The responsibilities of the Student Loan Committee are transferred to the jurisdiction of the Executive Committee.]

Section 2—Committee Structure

Except as otherwise stated in the Bylaws, *with specific reference to Chapter V, Section 8A,* a Committee shall consist of not less than 4 nor more than 5 members, appointed from the general membership of the Association and shall be appointed annually by the President. The President shall also appoint the Chairman [and the Vice Chairman] of each Committee. *The committee chairman shall appoint a vice chairman.*

Section 3—Commission Structure

Each Commission will consist of 15 members appointed by the President, with at least one member from each Trustee district. The original appointees in each commission shall be divided into three groups by lot. The first group shall serve three years; the second, two years; and the third, one year. Thereafter, each incoming President shall appoint five members of each commission to fill the vacancies resulting from the expiration of the terms of members, and such appointments shall be for three years. The President shall also appoint members to fill the unexpired term where any vacancy occurs through death, resignation or otherwise. The President shall appoint the chairman [and the vice-chairman] of each commission. *The commission chairman shall appoint a vice chairman.*

Section 4—Removal of Members

The President shall have the power, with the approval of the Board, to remove any member of any committee or commission where such member, for any reason, does not or cannot work at attempting to perform the duties pertaining to membership on such committee or commission.

Section 5—Terms

Unless otherwise provided in these Bylaws, no member of either a committee or a commission shall serve on the same committee or a commission more than two consecutive terms, but this shall not prevent his serving more than two terms if the term of another member intervenes. The time given to the serving of an unexpired term shall not be considered in determining the period within which a member may serve consecutively.

Section 6—Initial Meeting

Within sixty days after the meeting of the State Convention, the President will call all commissions and committees into a joint meeting in which he will give a statement of the duties and responsibilities of all committees and commissions, call special attention to any immediate problems confronting the Association, and assign such problems or parts thereof to appropriate committees and commissions. In these meetings the commissions may provide for such subcommissions within the separate commissions as they may deem advisable. Each committee or commission shall have the right to call upon other committees, commissions or members of the profession for counsel and advice with respect to its work.

Section 7—Coordination of Activities

Each committee and commission shall have the privilege and is encouraged to have joint meetings with any like committee or commission of the Auxiliary where such like committee or commission exists, for the purpose of coordinating their activities to make them more effective in the medical service of the public and the intent of the Association.

Section 8—Duties and Responsibilities

Each committee and commission shall have the duty and responsibility of keeping constantly and currently informed on the matters within the area of its special interest and activity; of studying the conditions within that area with the purpose of finding possibilities of improvement; of finding the best solutions it can to the specific problems referred to it; of contributing in its area to the achievements of the Association as a whole in the protection and improvement of the health of the whole human family and finally of making all its efforts useful by passing on to the Association in the most effective manner possible the results of its studies and activities in its own area of special interests.

A. The Grievance Committee

—The duties of this committee shall be to receive complaints, appeals or suggestions from physicians or laymen concerning professional conduct. It shall attempt to find the facts regarding any matter brought to its attention, through procedures proper and appropriate to that end, and shall attempt to adjust differences between patients and physicians, and between physicians. It may, if it believes the facts justify such action, cite a member of the Association to the Board of the State Association. It shall, subject to the approval of the Board, draw up a set of rules and regulations governing its procedure and official action.

B. The Future Planning Committee

—The function of this committee shall be to study and anticipate future trends and to stimulate the various commissions in coordinated directions so there is concord to the entire operation of Indiana State Medical Association. It is not contemplated that it be an operational committee.

C. The Medical-Legal Review Committee

—The Medical-Legal Review Committee shall consist of three members *selected from the Indiana State Medical Association* whose duty it shall be to meet in joint session and work with a similar committee *of three members of the State Bar Association* to be appointed by [the President of] the *Indiana* State Bar Association. [This committee] *These three members* of the Medical Association shall function as the medical representatives provided for in the Joint Inter-Professional Code of the State Medical Association and the State Bar Association to carry out the purposes of that Code. Its duties shall be as stated in that Code in the form in effect from time to time as approved by the Association, and in all other medical-legal matters.

D. The Commission on Medical Services

—The Commission on Medical Services shall concern itself and assume special responsibility in obtaining information and giving counsel and advice to the Association with respect to all matters in which medical service comes into contact with any existing or proposed functions of government, including civil defense, rehabilitation of persons handicapped by abnormality or disease, medical service in welfare departments, maternal and child health programs sponsored through governmental agencies, medical care of military manpower, plans and programs for medical care of veterans, medical care for dependents of those in uniformed services of the government, plans and programs of the government for medical care now existing or which may hereafter be adopted by any special group, government programs for elimination of venereal disease and other communicable diseases, and all programs and plans for medical care to be provided through municipal, state or federal governments.

E. The Commission on Medical Education

—The Commission on Medical Education shall maintain liaison with, and try to be of assistance to, medical schools and the licensing board; and shall keep in contact with, and endeavor to assist in improving, undergraduate education, postgraduate education, intern training, resident training, preceptor instruction, and public school health education.

F. The Commission on Legislation

—The Commission on Legislation shall study all legislation, both state and national, and all local legislative trends and movements, as to their effect upon the practice of medicine and the protection of the public health; shall keep the profession informed at all times concerning the matters within its area of responsibility; shall conduct investigations of legislative proposals; and shall maintain liaison with members of the State Legislature and the United States Congress, and with the legislative activities of the American Medical Association. It shall strive to implement and make effective the legislative proposals adopted by the Association.

G. The Commission on Constitution and Bylaws

—The Commission on Constitution and Bylaws shall keep in contact with the development and changes in procedures in carrying on the work of this Association; shall suggest revisions necessary to keep the Constitution and Bylaws always in accord with the practices and procedures best adapted to the functioning of the Association; and shall keep the practices and procedures of the

Association consistent with the provisions from time to time contained in the Constitution and Bylaws—to the end that all members of the profession, by reference to the Constitution and Bylaws, may be able to obtain accurate information regarding procedure and practice within the Association, and that hampering of such procedure and practice by obsolete provisions in the Constitution and Bylaws may be avoided.

H. The Commission on Public Relations

—The Commission on Public Relations shall collect and organize for dissemination to the public all matters of public interest within the field of medicine, including the activities of other commissions in which the public interest would be involved, and including also the achievements in the advancement of medicine which would be of interest to the public; shall disseminate all such information through the use of whatever media the commission may find adaptable to that purpose so that such information may be brought to the public in the most effective and convincing manner; and shall develop and maintain the relations of the medical profession with the public in such a way as to give the lay public a better knowledge and understanding of the aims, objects and value of the profession to the public.

I. The Commission on Convention Arrangements

—The Commission on Convention Arrangements, with the advice and assistance of the Executive *Director,* shall provide suitable accommodations for meetings of the Association, including the House of Delegates, Board, and of their respective committees, the scientific and and technical exhibits, and in conjunction with the Executive *Director,* shall have general charge of all the arrangements. Its chairman shall report an outline of the arrangements to the Executive *Director* of the Association for publication in THE JOURNAL and in the official program, and shall make additional announcements during the session as occasion may require. The arrangements and the character of any and all technical exhibits must meet with the approval of the Executive Committee of the Association.

—It shall, with the approval of the Executive Committee, prepare a program for scientific work for the Annual Convention in which shall be included the respective programs for section meetings which shall be prepared through cooperation with the officers [on] *of* the various sections; and it shall, with the approval of the Executive Committee arrange for scientific exhibits as a part of the Annual Convention.

—The general, scientific and sectional programs, and the financial arrangements to provide for them must be approved by the Executive Committee before being officially announced.

Section 9—Ex Officio Members

The President, *President-elect,* Executive *Director,* Speaker and Vice-Speaker of the House shall be ex officio members of all the foregoing committees and commissions without voting rights where their inclusion on the committee or commission is not otherwise provided for in these Bylaws.

CHAPTER X—RECIPROCITY OF MEMBERSHIP WITH OTHER STATE SOCIETIES

In order to broaden professional fellowship, this Association is ready to arrange with other State Medical Associations for an interchange of certificates of membership so that members moving from one state to another may avoid the formality of reelection.

CHAPTER XI—REFERENDUM

Section 1—Procedure

A general meeting of the Association may, by a two-thirds vote of the members present, order a general referendum on any question pending before the House of Delegates, and when so ordered the House of Delegates shall submit such question to the members of the Association, who may vote by mail or in person, and if the members voting shall comprise a majority of all members of the Association, a majority of such vote shall determine the question and be binding on the House of Delegates.

The House of Delegates may, by a two-thirds vote of its own members, submit any question before it to a general referendum, as provided in the preceding section, and the result shall be binding on the House of Delegates.

CHAPTER XII—THE SEAL

The Association shall have a common Seal, with power to break, change or renew the same at pleasure.

DIVISION FOUR—

COUNTY AND DISTRICT SOCIETIES

CHAPTER XIII—COUNTY SOCIETIES

Section 1—Charters

—All county societies now in affiliation with this Association or those which may hereafter be organized in this state, which have adopted principles of organization not in conflict with this Constitution and Bylaws, shall, on application receive a charter from and become a component part of this Association. The acceptance or retention of this charter shall be regarded as a pledge on the part of said component society to conduct itself in harmony with the letter and spirit of this Constitution and Bylaws and other rules and resolutions of this Association.

—Charters shall be issued only upon approval of the Board and shall be signed by the President and Executive *Director* of this Association. The Board shall have authority to revoke the charter of any component society whose actions are in conflict with the letter and spirit of this Constitution and Bylaws.

—Only one component medical society shall be chartered in any county. Where more than one county society exists, friendly overtures and concessions shall be made, with the aid of the Trustee for the district if necessary, and all of the members brought into one organization. In case of failure to unite, an appeal may be made to the Board, which shall decide what action shall be taken.

Section 2—Membership Qualifications

—Each county society shall be judge of the qualifications of its own members, but, as such societies are the only portals to this Association and to the American Medical Association, every reputable and legally registered physician who holds a degree of Doctor of Medicine, a degree of Bachelor of Medicine or who holds a valid, unrestricted license to practice medicine and surgery, and who does not practice or claim to practice, nor lend his support to, any exclusive system of medicine, shall be eligible for membership. Provided, however, that each county society may deny membership in such society for infraction or violation of any law relating to the practice of medicine or of the Constitution and Bylaws of such society, the Constitution and Bylaws of the Indiana State Medical Association or for a violation

of the Principles of Medical Ethics of the American Medical Association; and may, after due notice and hearing, censor, suspend or expel any member for any such infraction. Before a charter is issued to any county society, full and ample notice and opportunity shall be given to every physician in the county to become a member.

Section 3—Right of Appeal

—Any physician who may feel aggrieved by the action of the society of his county in refusing him membership, or in suspending or expelling him, shall have the right to appeal to the Board, and its decision shall be final.

—In hearing appeals the Board may admit oral or written evidence as in its judgment will best and most fairly present the facts, but in case of every appeal, both as a board and as individual Trustees in district and county work, efforts at conciliation and compromise shall precede all such hearings.

Section 4—Membership Transfer

—When a member in good standing in a component society moves to another county in this state, his name shall be transferred without cost to the roster of the county society into whose jurisdiction he moves, provided the transfer is approved by majority vote of the membership of said society to which the transfer is proposed.

—A physician who has the major part of his practice in a county other than the county in which he resides may hold its membership in the county society of his residence or in the county society of the county in which he has the major part of his practice. However, no physician shall hold active membership in more than one county society at the same time.

Section 5—Direction of Profession

—Each component society shall have general direction of the affairs of the profession in its county, and its influence shall be constantly exerted for bettering the scientific, moral and professional status of every physician in the county; and systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified and honorable physician in the county.

Section 6—Selection of Delegates

—At the annual business meeting for election of other officers, in advance of the Annual Convention of this Association, each county society shall elect delegates and alternates to represent it in the House of Delegates of this Association, and the secretary of the society shall send a list of such delegates and alternates to the Executive *Director* of this Association annually on or before February 1.

Section 7—Secretarial Duties

—The secretary of each component society shall keep a roster of all its members and of the non-affiliated registered physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this state, and such other information as may be deemed necessary. In keeping such roster the secretary shall note any changes in the personnel of the profession by death, or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

The secretary of each component society shall prepare and send to the Trustee of his district a quarterly report briefly stating the activities of his county society including meetings, programs, changes in officers and personnel of membership. A copy of this quarterly report to the Trustee shall also be sent to the Executive *Director* of the State Association. The State Association shall suppy each county secretary a form for these reports.

Section 8—Fiscal Year and Dues

—The fiscal year of the Association shall be from October 1 to September 30 of the succeeding year. The dues shall be collected by the calendar year and payable in advance.

Unless collected by the Indiana State Medical Association, the secretary of each component society shall forward the dues for his society to the Executive *Director* of this Association and shall furnish the State Association Headquarters with a roster of officers, members and a listing of non-affiliated physicians of the county, on or before January 1 of each year, and he shall promptly report thereafter the names of any new members elected to membership in his society, and promptly forward to the Executive *Director* of this Association the dues for such members.

The dues and the rights and benefits of all members shall be as provided in Chapter I, Section 1, et seq. of the bylaws.

[The dues shall be the same for all members and entitle the members to all benefits, including the publications of this Association, from the time of paying the dues to the close of the year only.] Provided, however, that physicians elected to their first membership in this Association during the first six months of any year shall pay the regular annual dues for that year; and those elected to their first membership after July 1 of any one year shall pay fifty percent of the annual dues as dues for the remainder of that year. Interns and residents shall pay annual dues during their term of service in the hospital at a reduced rate established by the Board of Trustees.

In the event the county society *relieves* a member *from the payment of* dues on account of financial hardship, the secretary of the county medical society shall recommend in writing to the Trustee of his district the *relief from* State Association dues of said member of the society, showing why such recommendation should be granted. The Trustee in turn shall present the recommendation to the Board, which shall have the power to *relieve a member of dues.*

Section 9—Failure to Pay Dues

—Any county society which fails to pay its dues or make the report required by February 1 of each year shall be held suspended, and none of its members or delegates shall be permitted to receive any of the publications of the Association or participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 10—Secretary Direction

—Each county society shall be held responsible for the faithfulness in the performance of duty on the part of its secretary in making reports and remitting dues to the Association.

Section 11—Constitution and Bylaws

—Each component society shall have its own Constitution and Bylaws, which shall not be in conflict with the Constitution and Bylaws either of this Association or of the American Medical Association. An up-to-date copy thereof shall be filed with the Executive *Director* of the Indiana State Medical Association not later than May 1 of each calendar year, or where such copy is so on file and no change has been made, then it shall be sufficient to file a certificate to that effect with said Executive *Director.*

CHAPTER XIV—

TRUSTEE DISTRICT MEDICAL SOCIETIES

Section 1—Composition

—A Trustee District Medical Society, hereinafter called the district society, shall be a society whose members consist of the members of the county medical societies in the counties which constitute the Trustee district.

Section 2—Number of Districts

—The state shall be divided into thirteen (13) Trustee districts with the boundary lines and numbers of each district to be as follows:

First District—Posey, Vanderburgh, Warrick, Spencer, Perry, Pike and Gibson Counties.

Second District—Knox, Daviess, Martin, Monroe, Owen, Greene and Sullivan Counties.

Third District—Dubois, Crawford, Harrison, Floyd, Clark, Scott, Washington, Orange and Lawrence Counties.

Fourth District—Jackson, Jennings, Jefferson, Switzerland, Ohio, Dearborn, Ripley, Decatur, Batholomew and Brown Counties.

Fifth District—Clay, Vigo, Vermillion, Parke and Putnam Counties.

Sixth District—Shelby, Rush, Fayette, Franklin, Union, Wayne, Henry and Hancock Counties.

Seventh District—Morgan, Johnson, Marion and Hendricks Counties.

Eighth District—Madison, Delaware, Randolph, Jay and Blackford Counties.

Ninth District—Fountain, Montgomery, Boone, Hamilton, Tipton, Clinton, Tippecanoe, Warren, Benton, White, Newton and Jasper Counties.

Tenth District—Porter and Lake Counties.

Eleventh District—Carroll, Howard, Grant, Huntington, Wabash, Miami, and Cass Counties.

Twelfth District—Wells, Adams, Whitley, Allen, Noble, DeKalb, LaGrange and Steuben Counties.

Thirteenth District—Pulaski, Fulton, Kosciusko, Marshall, Starke, LaPorte, St. Joseph and Elkhart Counties.

Section 3—Constitution and Bylaws

—Each district society shall adopt a Constitution and Bylaws, which shall not conflict with the Constitution and Bylaws of the State Association, and only one district society shall exist within any one Trustee district. The authorized district society in each Trustee district shall receive a charter from the State Association, and the Secretary of the district society shall have custody of the charter.

Section 4—Officers

—Each district society shall organize by electing a president, a secretary and a treasurer and Trustee(s) and Alternate Trustee(s) as the current Trustee(s) term and Alternate Trustee(s) term for the district expires, and such others as may be provided for in its Constitution and Bylaws. The office of secretary and treasurer may be held by the same physician. The Trustee(s) shall continue to have the same duties and terms as are set forth in the Constitution and Bylaws of this Association.

Section 5—Trustee Allocation

—Each district society shall have one Trustee and one Alternate Trustee for each 600 active members or major fraction thereof but in any event each district shall have one Trustee and one Alternate Trustee. The term of each trusteeship newly created by the numerical growth of a district shall begin at the organization meeting of the Board immediately following the adjournment of the second meeting of the House of Delegates at the next annual meeting, in accordance with Chapter VII, Section 6A.

Section 6—Dues

—The dues of the district society, in an amount fixed by the district society to meet the society needs, shall be collected by the secretaries of the component county societies, or by the Indiana State Medical Association and delivered to the treasurer of the district society. The secretary of each district society shall report to the office of the Indiana State Medical Association the names and addresses of the members of his district society, together with a copy of the minutes of each meeting of his district society.

Section 7—Meetings

—Each district society shall meet at least once each year at a time and place to be fixed by the district society. On or before January 1 of each year each district society shall notify the headquarters of the State Association of the time and place of the annual district meeting for that year; but if no such notification has been received in the headquarters on or before the January meeting of the Board, the Trustee shall fix the time and place of the district meeting, and notice of such meeting shall be sent to the members of the county medical societies in such district.

Section 8—Notification to Headquarters

—Whenever a district society is to elect a Trustee and/or Alternate, the headquarters office of the State Association shall so notify the individual members of such district society not later than the first of March of the year in which the election is to occur.

—The district society shall send to the headquarters office of the State Association a copy of its program showing the time and place of its meetings, early enough that the headquarters office may notify all members within the district of the meeting at least thirty (30) days prior to the date thereof.

Section 9—Election to Blue Shield

—It shall be the duty of each district medical society to select in any manner it chooses a member from its district to serve a term or fill an unexpired term on the Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield). Notice of such selection shall be immediately transmitted to the Board of Trustees of the Indiana State Medical Association which will officially place said selected member in nomination for election to said Board of Directors.

Any member selected or nominated to serve on the Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) may serve an unlimited number of three year terms as approved by his constituent county medical societies. The Board of Directors of Mutual Medical Insurance, Inc., (Blue Shield) should prepare a list of needed qualifications for nomination to this office.

DIVISION FIVE—MEDICAL DEFENSE

CHAPTER XV—MEDICAL DEFENSE ADMINISTRATION, AUTHORITY AND PROCEDURES

Section 1—Dues Allocation

—One dollar and twenty-five cents ($1.25) out of the annual dues of each member of the Association shall be set aside as a special fund for medical defense.

Section 2—Administration

—The administration of medical defense of this Association shall be intrusted to the Executive Committee, which shall constitute the Medical Defense Committee of the Association.

Section 3—Authority

—This committee shall have full authority governing all matters pertaining to this Chapter. In order to insure

a fair and full presentation of defense for any member physician sued or against whom claim is made, the committee shall have the power to employ and pay an attorney of their choice as a consultant to the committee, and such other expenses as the committee may approve as necessary. It is expected that the committee's consultant attorney will provide necessary communication with the member-physician's personal attorney.

Section 4—Custodian of Funds

—The Treasurer of the Indiana State Medical Association shall be custodian of the defense fund, separately kept, and shall give such additional bond as may be demanded by the Medical Defense Committee. Payments out of this fund shall be made only upon approval of the Executive Committee, by checks signed by the Treasurer and the chairman of the Board.

Section 5—Annual Report

—The Medical Defense Committee shall make an annual report to the House of Delegates of the cases in which it has been of service to members and furnish an account of the money received and expended, such report to be published in THE JOURNAL of the Indiana State Medical Association at the time and in the manner that reports of other committees of the Association are published.

Section 6—Liability

—This Association shall not be liable for any damage awarded, but shall be liable only for such expenses for the legal defense of its members as may be incurred in accordance with the terms of these Bylaws.

Section 7—Eligibility

—The Association shall not undertake the defense of a member in any case in which the member who applies for medical defense by the Association has failed to pay his annual dues for the year in which services were rendered which are the basis of the suit; and medical defense by the Association shall not be available in any suit based on services rendered during any period of delinquency in the payment of dues. Dues are payable on January 1, and become delinquent on February 1 of each year. The membership card of this Association, duly signed and dated by the Executive *Director,* shall be considered the only *bona fide* evidence of payment of dues or membership in this Association.

The Indiana State Medical Association shall in no case provide medical defense against any action for alleged malpractice against any physician unless such physician was a member of this Association in good standing at the time the services, which are the basis of the suit, were rendered.

Section 8—Filing for Defense

—A member desiring to avail himself of the services of the Medical Defense Committee in connection with litigation brought or threatened must send to the Executive *Director* of the Association for an application blank. After completing the data concerning the case he shall submit to a local committee of his county medical society—to be composed of the president, secretary and one other member in good standing who may be nominated by the defendant—a full statement of the question at issue, including the diagnosis and treatment of the case and the names of physicians, nurses and other persons having knowledge of the same, who may be summoned as witnesses.

Section 9—County Society Committee

—The committee of the county medical society shall immediately, after an investigation of all the circumstances and facts, transmit its report, with recommendations, to the Medical Defense Committee of this Association.

Section 10—Appeal

—In the event that the county committee shall fail to recommend the case as one worthy of the recognition of this Association, a direct appeal may be made to the Medical Defense Committee of this Association, whose decision shall be final.

Section 11—Deceased Member

—Suits brought against the estate of a deceased member shall be defended as if that member were alive; provided that such member was in good standing in the Association at the time of his death and that services for which indemnity is asked were rendered while the deceased was a member in good standing.

Section 12—Locality Restrictions

—Medical defense shall not be available to members living outside of the State of Indiana at the time services were rendered for which indemnity is claimed.

Section 13—Adoption of Rules

—The Medical Defense Committee shall have power to adopt such other rules, not in conflict with the foregoing, as in their judgment may seem necessary.

Section 14—Terms of Defense

—Medical defense as provided for by this Association shall be available to members under the terms stated in these Bylaws only in the defense of civil action for alleged malpractice, and shall not be available if such alleged malpractice occurred when the member was under the influence of any intoxicant or narcotic while rendering the service in question.

DIVISION SIX—MISCELLANEOUS

CHAPTER XVI—DIVISION OF FEES

This Association does not countenance or tolerate fee-splitting, division of fees, or commission paying directly or indirectly, and any member found guilty shall be expelled from membership.

CHAPTER XVII—PARLIAMENTARY PROCEDURE

—The deliberations of this Association shall be governed by parliamentary usage as prescribed in the current edition of Sturgis Standard Code of Parliamentary Procedure, when not in conflict with this Constitution and Bylaws.

CHAPTER XVIII—AMENDMENTS

Section 1.—These Bylaws may be amended at any Annual Convention by a majority vote of all the delegates present at that convention, after the amendment has lain on the table for one day.

Sec. 2.—Upon the adoption of this Constitution and Bylaws all previous Constitutions and Bylaws are hereby repealed.

CHAPTER XIX—MEDICAL ETHICS

The Principles of Medical Ethics of the American Medical Association shall govern the conduct of members in their relations to each other and to the public.

Principles of Medical Ethics of the American Medical Association

PREAMBLE

These principles are intended to aid physicians individually and collectively in maintaining a high level of ethical conduct. They are not laws but standards by which a physician may determine the propriety of his conduct in his relationship with patients, with colleagues, with members of allied professions, and with the public.

Section 1.—The principal objective of the medical profession is to render service to humanity with full respect for the dignity of man, Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion.

Section 2.—Physicians should strive continually to improve medical knowledge and skill, and should make available to their patients and colleagues the benefits of their professional attainments.

Section 3.—A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle.

Section 4.—The medical profession should safeguard the public and itself against physicians deficient in moral character or professional competence. Physicians should observe all laws, uphold the dignity and honor of the profession and accept its self-imposed disciplines. They should expose, without hesitation, illegal or unethical conduct of fellow members of the profession.

Section 5.—A physician may choose whom he will serve. In an emergency, however, he should render service to the best of his ability. Having undertaken the care of a patient, he may not neglect him; and unless he has been discharged he may discontinue his services only after giving adequate notice. He should not solicit patients.

Section 6.—A physician should not dispose of his services under terms or conditions which tend to interfere with or impair the free and complete exercise of his medical judgment and skill or tend to cause a deterioration of the quality of medical care.

Section 7.—In the practice of medicine a physician should limit the source of his professional income to medical services actually rendered by him, or under his supervision, to his patients. His fee should be commensurate with the services rendered and the patient's ability to pay. He should neither pay nor receive a commission for referral of patients. Drugs, remedies or appliances may be dispensed or supplied by the physician provided it is in the best interests of the patient.

Section 8.—A physician should seek consultation upon request; in doubtful or difficult cases; or whenever it appears that the quality of medical service may be enhanced thereby.

Section 9.—A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community.

Section 10.—The honored ideals of the medical profession imply that the responsibilities of the physician extend not only to the individual, but also to society where these responsibilities deserve his interest and participation in activities which have the purpose of improving both the health and the well-being of the individual and the community.

Legislation

ACTION: Referred to ISMA Board of Trustees.

The short session of the 99th General Assembly was once again, like that of 1975, a very productive one for organized medicine in Indiana.

H.B. 1310, which encompassed several technical changes to P.L. 146, was passed and signed into law by Governor Otis R. Bowen, M.D., on Feb. 25, 1976, which should strengthen the constitutionality of P.L. 146. The changes were in the areas of self insurance, annual aggregate, joint liability of employees, minimum surcharge, time limit on screening panels, and a broader definition of a health care provider. All this was accomplished through the efforts of the Medical Malpractice Study Commission, chaired by Gilbert M. Wilhelmus, M.D., which was created by the 1975 General Assembly, and the dedicated physicians of the Indiana State Medical Association who kept the legislators well informed of the need for these changes.

The Commission on Legislation will continue to study this problem, along with the Study Commission, and will initiate further changes, if change is indicated.

Another major accomplishment by your Commission, ISMA physicians, and ISMA's lobbyists Richard Guthrie and Fred Garver, was the sustaining of Governor Bowen's veto of S.B. 111, the Foreign Medical Graduates Bill.

In addition to these two bills, your Commission looked at 71 other medically related bills which could have a direct bearing on physicians and health care in the state of Indiana. None of the 13 bills on health subjects that were enacted into law were opposed by the Indiana State Medical Association through the Commission on Legislation.

The rapport between the Commission and the three physician legislators—E. Henry Lamkin, Jr., M.D., Indianapolis; Anthony Pizzo, M.D., Bloomington and Floyd Coleman, M.D., Waterloo—has been a tremendous help in accomplishing the above.

After the short session of the General Assembly ended, the Commission met in April and decided to support the Medical Licensing Board's position that it possesses the necessary authority under the Medical Practice Act to register P.A.s in Indiana and not to sponsor or support a P.A. bill during the next session if the Medical Practice Act can be used. The Commission also agreed to cooperate with the State Board of Health and State Legislative Committee in developing a certificate of need bill which would be introduced during the next session of the General Assembly.

James J. Stewart, ISMA attorney, was asked to provide the Commission with a recommended solution to the duplicate payment of registration fee for controlled substances which could be introduced at the next session of the General Assembly. The Commission also moved that Mr. Stewart be allowed to aid the Medical Licensing Board, at ISMA's expense, in setting up procedures for getting increased funds for the Board and for the promulgation of rules and regulations of the Medical Practice Act. This was approved by the Executive Committee.

The Commission then discussed substitution legislation and voted to oppose such a bill if introduced at the next session of the General Assembly. Another area of discussion was definition of death legislation. The Commission felt that an ad hoc committee, made up of physicians from the specialties who have the most knowledge in this area, should study the need for definition of death legislation in Indiana. The ad hoc committee has been appointed by Vincent J. Santare, M.D. and will report back to the Commission prior to the next session of the General Assembly.

The Commission has also asked our legal counsel to write a resolution or bill which would provide any doctor civil immunity from retrospective review, concurrent review and post review.

The Commission is scheduled to meet again on September 16, 1976, to prepare any new legislation or study new proposed legislation which could have a direct bearing on the health care delivery system in Indiana.

As chairman, I would like to take this opportunity to say thank you to all the hard working members of the commission as well as to all the others who contributed their time and energy to help support the positions taken by the Commission and your State Medical Association.

PAUL F. MULLER, M.D.
Chairman

JAMES A. MARVEL, M.D., PAUL J. WENZLER, M.D., PETER H. LIVINGSTON, M.D., WILLIAM F. BLAISDELL, M.D., WILLIAM G. BANNON, M.D., JOHN A. DAVIS, M.D., JOHN G. PANTZER, MD., RICHARD L. REEDY, M.D., JOHN A. KNOTE, M.D., LEONARD W. NEAL, M.D., RICHARD L. GLENDENING, M.D., JERRY L. STUCKY, M.D., ROBERT M. SWEENEY, M.D., JAMES M. KIRTLEY, M.D., DON E. WOOD, M.D., MALCOLM O. SCAMAHORN, M.D., JOHN B. WHITE, JR., M.D., PHILIP N. ESKEW, JR., M.D., PELAYO B. CABRERA, M.D., JOSEPH M. BLACK, M.D., JOHN G. PANTZER, M.D., JAMES A. HARSHMAN, M.D., WALTER HUNTER.

Medical Education

ACTION: Filed.

The Commission on Medical Education and its Committee on Accreditation held three meetings this year. The following actions were taken:

1. Reviewed site team surveys together with accreditation request data supplied by hospitals and societies seeking accreditation. Site teams actually visited each hospital accredited.

2. Developed and began resurvey and reaccreditation processes of hospitals whose term of CME accreditation was approaching expiration date.

3. Approved CME accreditation or reaccreditation of the following hospitals and specialty societies:

*St. Joseph's Hospital, South Bend
*Memorial Hospital, South Bend
Indiana OB/GYN Society
Fort Wayne Medical Education Program (Lutheran, Parkview, St. Joseph's Hospital, Fort Wayne Medical Society)
St. Vincent Hospital, Indianapolis
St. Mary's Hospital, Evansville
Terre Haute Regional Hospital, Terre Haute
Dearborn County Hospital, Lawrenceburg
Mercy Hospital, Elwood
*Reid Memorial Hospital, Richmond
Indiana Urological Society
Aesculapian Society, Terre Haute
**St. Margaret's Hospital, Hammond

4. Reviewed scientific programs of 1976 ISMA State Convention and approved as Category I, Accreditable Material in the AMA, PRA.

5. Issued distinguished membership cards to recipients of PRA. In the first 6 months of 1976, 253 PRAs were awarded to Indiana M.D.s, as compared to 125 in like period of 1975.

6. Accredited a total of 23 Indiana hospitals and 11 specialty societies in Category I programs.

7. Recommended consideration by ISMA Trustees that CME participation become prerequisite to ISMA membership.

8. The following Commission members provided liaison with other groups:

Indiana Medical Licensure Board
Ernest R. Beaver, M.D.
Accreditation Committee Chairman
Eugene M. Gillum, M.D.
AIDME
John L. Cullison, M.D.
Division of Postgraduate Education of I.U.
John Phillips, M.D.

*Extension or reaccreditation
**Has been surveyed and in all probability will be approved at the September meeting.

Convention Arrangements
Russell L. Judd, M.D.
John Roscoe
Family Practice
Eugene M. Gillum, M.D.
Representative to Board of Trustees
Franklin Bryan, M.D.
Student Affairs
Phillip Doering
House Staff
Robert Rankin, M.D.
Commission on Legislation
Steven C. Beering, M.D.

Commission on Medical Education
STEVEN C. BEERING, M.D.
Chairman

ROBERT H. OSWALD, M.D., GEORGE N. LEWIS, M.D., RICHARD RIEHL, M.D., LESLIE M. BAKER, M.D., ROBERT OEHLER, M.D., DAVIS W. ELLIS, M.D., DONALD M. SCHLEGEL, M.D., EUGENE M. GILLUM, M.D., LINDLEY WAGNER, M.D., NICHOLAS L. POLITE, M.D., SHOKRI RADPOUR, M.D., RONALD H. SCHEERINGA, M.D., WALLACE S. TIRMAN, M.D., ERNEST R. BEAVER, M.D., FRANKLIN A. BRYAN, M.D., JOHN L. CULLISON, M.D., JOHN ROSCOE, JOHN PHILLIPS, M.D., ROBERT RANKIN, M.D., PHILLIP DOERING, CLEON SCHAUWECKER, M.D.

Subcommission on Accreditation
EUGENE M. GILLUM, M.D.
Chairman

JOHN CULLISON, M.D., MICHAEL A. HOGAN, M.D., DONALD M. SCHLEGEL, M.D., WILLIAM FECHTMAN, M.D., EMMETT C. PIERCE, M.D., WILLIAM D. RAGAN, M.D., RAYMOND O. PIERCE, M.D., JEFFREY KELLAMS, M.D., CHARLES HELMEN, M.D., NORMAND T. TOWNLEY, M.D., WILLIAM G. BANNON, M.D., RUSSELL L. JUDD, M.D., DONALD F. MacLEOD, M.D., JOHN V. OSBORNE, M.D., STEVEN C. BEERING, M.D., FRANKLIN A. BRYAN, M.D., DAVIS W. ELLIS, M.D., SHOKRI RADPOUR, M.D., JOHN ROSCOE

Medical Services

ACTION: Referred to Board of Trustees for consideration of recommendations by Reference Committee.

The Commission on Medical Services has held three meetings since the reorganization of ISMA commissions and committees. The Commission on Medical Services has spent most of its effort in evaluating previous responsibilities so as to better address the proper management of these responsibilities under the new structure. Previous program areas that were assigned to the newly constituted Commission on Medical Services include:

Emergency Medical Services
Aging
Public Health
Voluntary Health Agencies
Sports and Medicine
Governmental Medical Services
Medical Economics and Insurance

Dr. Lowell Hillis was appointed vice chairman of the Commission on Medical Services. Paul Inlow and Martin O'Neill represent the Board of Trustees on this commission.

Aging

No subcommission on aging was developed. Problems of aging will be worked on when specific projects are developed. One area for possible activity will be the development of a project for aging physicians—specifically, to develop a training program or programs for physicians to function as medical directors for nursing homes.

Sports and Medicine

Following the success of the ISMA efforts of 1975 in this field, some difficulty has been encountered in maintaining the momentum of this program. The difficulty is centered mostly in developing an ongoing group of medical leadership. It is hoped that difficulties can be resolved and the program be carried forward in the near future.

Voluntary Health Agencies

The activities of the previous Commission on Voluntary Health Agencies were all thought to be worth preserving and they were placed under the new Subcommission on Voluntary Health Agencies. The Subcommission on Voluntary Health Agencies approved 14 agencies of statewide organizations concerned with health problems. Approved are:

American Cancer Society, Indiana Division, Inc.
American Diabetes Association, Indiana Chapter
American Heart Association, Indiana Affiliate, Inc.
American Lung Association of Indiana
Arthritis Foundation, Indiana Chapter
Hemophilia of Indiana, Inc.
Indiana Committee to Combat Huntington's Disease, Inc.
Indiana Easter Seal Society for Crippled Children
Indiana Society for the Prevention of Blindness
Kidney Foundation of Indiana, Inc.
Mental Health Association in Indiana
National Cystic Fibrosis Research Foundation, Indiana
The National Foundation, March of Dimes
National Multiple Sclerosis Society, Indiana Chapter

Emergency Medical Services

The commission on Medical Services spent some time reviewing the history of emergency medical services in Indiana and assessing the current situation to determine the proper role or roles for ISMA and the Commission on Medical Services related to future development of emergency medical services in Indiana. For the past two and a half years the Governor's Commission on EMS has assumed the responsibility in this area previously held by the Indiana State Board of Health. Their first area of endeavor has been in the provision of ambulance service and development of a curriculum to train and certify paramedical professionals in that field. The Governor's Commission is now developing criteria for categorization of hospital services. These have been reviewed and endorsed by the Indiana State Hospital Association. The Commission on Medical Services is not aware of having been contacted for input in this matter. The role of the ISMA should be established at least by the Board of the ISMA. At present there does not seem to be any formal relationship other than sporadic communication between ISMA and the Governor's Commission.

There has been established a voluntary health agency known as the American Trauma Society. The society has an Indiana division. No application for approval as a voluntary health agency has been submitted to the ISMA as yet. Perhaps further communication to this end should be established.

Insurance

No action developing a captive company providing medical liability insurance is felt to be necessary at this time in light of the availability of such insurance coverage from commercial carriers. The Commission will keep abreast of the marked legislative and judicial actions in this area and make recommendations where appropriate.

Implementation of Resolution 75-5, ISMA Members' Self-Insurance Plan, has begun. Since this would require a budget and staff, an investigation must be undertaken before recommendations along this line can be made by the Commission on Medical Services. A membership opinion questionnaire developed by the Future Planning Committee will, if approved by the Board of Trustees, seek information from members concerning their interest in various forms of insurance coverage under an ISMA captive company or agency.

Governmental Medical Programming

CHAMPUS—Dr. Andrew Offutt is

now consultant to the Indiana CHAMPUS program. James Waggener is also serving in the position of administrator of this program.

Dr. Offutt reported CHAMPUS computer programming has been revised to that of the Medicare system although still administered nationally by the CHAMPUS Division of the Department of Defense headquartered in Denver, Colo. The major practical significance is that fees are based on the 75th percentile, Medicare data, whereas previously the basic guideline was the California relative value scale in most instances. Dr. Offutt has expressed Indiana's opposition to the new scale. In Indiana, CHAMPUS has processed 27,500 claims in 1975 through the ISMA intermediary function.

Dr. Offutt requested guidelines from the Commission on Medical Services for adjudicating claims for ileal bypass surgery. The Commission on Medical Services approved the following criteria:

TO: ALL CHAMPUS Providers
FROM: Indiana State Medical Ass'n. (CHAMPUS)
SUBJECT: Ileal Bypass Surgery

1. It is necessary that criteria be established on which an evaluation may be made for CHAMPUS claims based on above surgery. Because of this need certain claims presently being held for utilization review will be subjected to these criteria. If such a claim is pending from your practice you will receive a request to furnish the required information.

2. Criteria include:
 a. The patient must be at least 50% or 100 pounds overweight, whichever is greater.
 Morbid obesity is defined as a condition in which the presence of excess weight causes physical trauma; where pulmonary and circulatory insufficiencies are present; where complications exist related to the treatment of such conditions as arteriosclerosis, diabetes, coronary disease, etc.; and where the person is 50% or 100 pounds overweight.
 b. The morbid obesity must have existed for at least 5 years.
 c. Nonsurgical methods of weight reduction must have been attempted under a physician's supervision.
 d. The patient must be between 15 and 60 years of age. Note: If the patient is under 30, special attention should be given to letters "b" and "c," above.
 e. There must be good indications that the patient will remain hyperphagic postsurgically.

3. Where cases involve other aspects, it will be necessary to request additional information and review before providing benefits. It is to be noted that submission of the criteria above does not ensure affirmative action on the claim.

A committee to advise Dr. Offutt on CHAMPUS problems was established and includes five doctors: Paul E. Humphrey, Terre Haute; Albert M. Donato, Indianapolis; R. James Bills, Gary; Paul M. Inlow, Shelbyville, and Lee H. Trachtenberg, Munster. Specialists were to be consulted as needed.

Before renewal of the CHAMPUS contract in September 1977, the Commission on Medical Services should review the contract and compare it to the previous contract, if time permits. Recommendation should be made to the Board and/or the House of Delegates if enough time is allowed. Particular concern should be whether or not it is advisable for ISMA to continue its role as intermediary in the CHAMPUS program.

Dr. Donato reviewed Medicare and Medicaid and felt that a subcommittee should meet to establish a program for modifying the procedures to obtain state financing for health projects. The area looks promising and the work is continuing—all to be reported at a later date.

Public Health

A committee has met with Dr. Offutt and other knowledgeable people concerning public health in the state of Indiana as to the status of the swine vaccine for Indiana citizens and where the vaccine will be distributed. This is a difficult problem because the situation is mercurial from day to day. A blue-ribbon committee of five knowledgeable members of the State Medical Association plus five members from the Health Department of Marion County is keeping abreast of the situation and will make its best recommendations to Hoosier physicians and citizens as the situation develops.

Commission on Medical Services
LEE H. TRACHTENBERG, M.D.
Chairman

WALLACE M. ADYE, JR., M.D., ROGER F. ROBISON, M.D., EVERETT E. BICKERS, M.D., ROBERT O. ZINK, M.D., PAUL E. HUMPHREY, M.D., ROBERT E. TAUBE, M.D., ALBERT M. DONATO, M.D., THEODORE R. HAYES, M.D., ROBERT W. VERMILYA, M.D., R. JAMES BILLS, M.D., LOWELL J. HILLIS, M.D., R. WYATT WEAVER, M.D., JACK W. HANNAH, M.D., PAUL M. INLOW, M.D., WILLIAM R. GREENE, M.D., SARA THOMAS, ANDREW C. OFFUTT, M.D., MARTIN J. O'NEILL, M.D.

Subcommission on Sports and Medicine
R. WYATT WEAVER, M.D.
Chairman

WALLACE M. ADYE, JR., M.D., JACK M. WALKER, M.D.

Subcommission on Voluntary Health Agencies
ROBERT W. VERMILYA, M.D.
Chairman

MRS. RALPH MILBURN, MR. HAROLD WARD, CHARLES W. McCLARY, M.D., CHARLES RUSHMORE, M.D., LAWRENCE E. ALLEN, M.D., RUSSELL GRAF, M.D., WENDELL W. AYRES, M.D., WALFRED A. NELSON, M.D.

Subcommission on Insurance
ROBERT O. ZINK, M.D.
Chairman

JACK HANNAH, M.D., WILLIAM CAST, M.D., THOMAS J. CONWAY, M.D.

Public Relations

ACTION: Filed.

The Commission on Public Relations met three times during the year 1976. The first meeting was essentially an organizational meeting on goals. At the first meeting, a review of the ISMA welcoming packet was undertaken and it was thought that this should be updated by the staff and be available for the new physicians in the state. A motion was made to have the new packets sent to the Trustee of each district, who would, in turn, give them to the presidents of the county medical societies for distribution to the new doctors in the area.

The Health Insurance Association of America sent a letter to the State Medical Association entitled "Your Health Insurance." It was moved that the State Medical Association continue having this pamphlet available for physicians in the state of Indiana. It was also passed that an appropriate charge be made to regain the cost of the printing.

For the first time, a member of the Student Medical Association at Indiana University was appointed to the Commission. Mr. George Alcorn was appointed by the Indiana University branch of the Student Medical Association. His input was welcomed at these meetings.

The Commission also requested the Executive Committee to establish and publish a policy for relationships with laboratories, in view of the recent kickback scandals. The Commission also approved and sent to the Executive Committee its approval and recommendation that the Indiana State Medical Association take part in the Bicentennial issue of the Indianapolis Star to be published on July 4, 1976. A motion was made and approved that an ad depicting medicine in Indiana be placed in the July 4 issue.

At the final meeting of the Commission, the Speaker's Bureau was discussed and the following motion was made: The Indiana State Medical Association should renew its relationship with the Hopkins Syndicate with a ceiling of $15,000 per year for speaking engagements. The staff of the ISMA would approve each speaking engagement and a quarterly report be made to the Commission concerning speaking engagements, reception of the speakers and costs. It was also thought that spot announcements on controversial issues could be used in the field of radio and television and this was to be investigated as to cost and feasibility by staff.

One of the carry-overs from 1975 was the accountability session. The Commission discussed this at all three meetings and at the final meeting made a motion that the State Medical Association appoint a committee of five members to meet and listen to any individual or group that wanted to express ideas about improving medical care in Indiana. The committee would be instructed only to listen and to report to the House of Delegates anything they felt to be noteworthy. They were not to debate or discuss any issue with the participants. This was to be held the day before the opening of the Indiana State Medical Association annual meeting in October and each group or individual would be given five minutes to give their report. This motion was passed and sent to the Board of Trustees for approval. It was subsequently learned that in June the Board of Trustees turned this accountability session proposal down.

The Commission then took up the Medicare pamphlet, and it was decided that the Association delay any updating of the Medicare pamphlet until Congress decides what changes, if any, it is going to make.

I wish to thank the members of this committee who provided excellent service and input into the function of this Commission. The one disappointment was the turning down of the accountability session, which we believed would be good public relations with the people in the state. We hope this can be brought up again in a formal resolution at the House of Delegates with the State Medical Association deciding on this point.

JOHN W. LUCE, M.D.
Chairman

ALBERT S. RITZ, M.D., THOMAS O. MIDDLETON, M.D., JOSELITO LECAROS MILLAN, M.D., ROBERT P. ACHER, M.D., WILLIAM E. SCULLY, M.D., DONN R. HUNTER, M.D., ROBERT W. HARGER, M.D., PAUL BURNS, M.D., KENNETH J. AHLER, M.D., JOEL HULL, M.D., EUGENE T. KARNAFEL, M.D., MARVIN PRIDDY, M.D., HARRY G. BECKER, M.D., ROSS L. EGGER, M.D., FRED DAHLING, M.D., GABRIEL J. ROSENBERG, M.D., GEORGE ALCORN, WILLIAM M. SHOLTY, M.D., JOHN W. BEELER, M.D.

Resolutions

Resolution No. 76-1

Introduced by: Board of Trustees
Subject: GENERIC SUBSTITUTION OF A PRESCRIBED DRUG

HOUSE ACTION: Adopted.

Whereas, The patients of America have the right to expect that medications prescribed for them will be therapeutically effective; and

Whereas, Generic substitution of a prescribed drug may result in a patient receiving a drug which, although chemically equivalent, is not therapeutically equivalent; and

Whereas, There are documented instances in which generically and chemically equivalent drugs varied so greatly in therapeutic equivalence that the health and well-being of patients was endangered (for example, generic equivalents of Digoxin); and

Whereas, The Office of Technology Assessment of the United States Government has stated "Current standards and regulatory practices do not insure bioequivalence"; now therefore be it

Resolved, That the Indiana State Medical Association be opposed to generic substitution for a prescribed drug being done at the discretion of a pharmacist; and be it further

Resolved, That the Indiana State Medical Association make this organizational policy known to the legislature of the state of Indiana and to the AMA.

Resolution No. 76-2

Introduced by: Vanderburgh County Medical Society
Subject: SCOLIOSIS SCREENING PROGRAM

HOUSE ACTION: Adopted as amended.

Whereas, Approximately 11% of all school children develop scoliosis between the ages of 10 and 13; and

Whereas, When curvature of the spine is permitted to progress beyond 60 degrees, life expectancy is reduced by half; and

Whereas, The condition in adults is quite difficult and expensive to treat; and

Whereas, Severe deformity can be prevented if the condition can be identified and followed when a child is between the ages of 10 and 13; and

Whereas, Screening can be carried out quickly and effectively by properly trained personnel; now, therefore, be it

Resolved, That the Indiana State Medical Association communicate to the Indiana State Board of Health and to each separate school corporation throughout the state the basic elements of a scoliosis screening program for Indiana school children from grades five through eight and strongly urge the adoption of such a program.

Resolution No. 76-3

Introduced by: LaPorte County Medical Society
Subject: CREATION OF A COUNTERSUIT FUND

AND

Resolution No. 76-25

Introduced by: St. Joseph County Medical Society
Subject: SUPPORT FOR COUNTERSUIT

HOUSE ACTION: Substitute resolution adopted in lieu of resolutions 76-3 and 76-25.

Whereas, The Indiana State Medical Association recognizes the need for organized medicine to continue to pursue the goal of complete respite from the medical liability burden in the practice of medicine; and

Whereas, Encouraging countersuits against plaintiff and attorney seems to offer substantial and potential benefit for relief of some of this burden, both as a deterrent and a source of recompense for damages; and

Whereas, Other state medical associations are of like mind and are pursuing such a course; now, therefore, be it

Resolved, That the Board of Trustees and/or the Commission on Legislation of the Indiana State Medical Association be requested to investigate and develop mechanisms for support of such suits by its members; and be it further

Resolved, That such actions be communicated to the membership of this Association.

Resolution No. 76-4

Introduced by: Tippecanoe County Medical Society
Subject: FEE MEDIATION WITH INSURANCE COMPANIES

AND

Resolution No. 76-6

Introduced by: Steuben County Medical Society

Subject: ISMA AS A COLLECTIVE BARGAINING AGENT

AND

Resolution No. 76-10

Introduced by: Marion County Medical Society

Subject: MEDICINE'S ROLE IN HEALTH INSURANCE AND PATIENT/PHYSICIAN CONTACTS

HOUSE ACTION: Amended substitute resolution adopted in lieu of resolutions 76-4, 76-6 and 76-10

Whereas, We believe that the private insurance system has helped to make quality medical care available to the vast majority of Americans at a reasonable cost while allowing physicians to concentrate to a greater degree on the provision of that care; and

Whereas, We believe that the financing of medical care should be primarily the responsibility of the private sector of our economy; and

Whereas, There is agreement that there are problems with the current structure of medical financing: (a) the use of the "usual and customary" reimbursement program has produced inequities in the reimbursement of physicians, (b) emphasis on reimbursement for hospital-based services has produced an over-utilization of the hospital and its ancillary services and has contributed to the increased costs of medical care, (c) new and costly modalities of medical care, now available to the patient, could represent a severe financial burden to him or his family; and

Whereas, Physicians and organized medicine must take a strong leadership role in the education of the various groups seeking to shape the form of medical care provision and its financing; and

Whereas, Physicians and organized medicine must vigorously advocate the development of reasonably priced, freely chosen accessible and quality medical care; and

Whereas, A system of financing medical care should provide reasonable indemnity to the patient as well as provide equitable treatment to the physicians of Indiana, wherever they may practice; and

Whereas, Suggested systems for providing such equitable treatment include such options as: (a) statewide collective bargaining, (b) the formation of a state medical foundation for medical care, (c) Indiana State Medical Association to act as a party to insurance negotiations, (d) the adoption of insurance payment plans in substitution for "usual and customary;" now, therefore be it

Resolved, That the Board of Trustees and the appropriate committees and commissions of the ISMA study these and other alternatives and prepare a report for resubmission to this House of Delegates at its next annual meeting.

Resolution No. 76-5

Introduced by: Section on Allergy of ISMA

Subject: CREATION OF A DEPARTMENT OF ALLERGY AND IMMUNOLOGY

HOUSE ACTION: Not Adopted.

Whereas, 25 to 30% of patients seen by pediatricians are for an allergic problem; and

Whereas, More time is lost from school by children and teenagers because of allergic disease than from any other cause; and

Whereas, There are an estimated 50,000 asthmatics in Marion County alone; and

Whereas, Every state surrounding Indiana has medical schools with departments of allergy and immunology and accredited training programs in allergy and immunology; and

Whereas, Indiana University School of Medicine has no such department of allergy and immunology nor training program in this subspecialty; and

Whereas, Because of this, graduates of Indiana University School of Medicine are deficient in their ability to diagnose and treat allergic disease to the detriment of 15% of the population of Indiana; and

Whereas, Also because of Whereas No. 5, those interested in furthering their training in allergy and immunology must leave the state for this training and seldom return to Indiana to practice; and

Whereas, This has created a severe shortage of trained allergists in the state so that patients must frequently travel many miles and wait long periods of time to be seen and evaluated by properly trained men so that many go without proper care because of this scarcity of doctors trained to understand and care for these specialized problems; and

Whereas, Since allergy training now consists of conjoint Board of Allergy and Immunology and is a subspecialty in either internal medicine or pediatrics, and consists of two years of training in either of these specialities followed by two years training in allergy and immunology; therefore be it

Resolved, That the House of Delegates of the Indiana State Medical Association vote favorably on a resolution to use whatever means are possible to overcome this deficit which degrades Indiana University School of Medicine as a proper training center for doctors and is not in the true interest of the citizens of Indiana; and be it further

Resolved, That a Department of Allergy and Immunology and residency or fellowship training program in the same be created at the Indiana University School of Medicine; and be it further

Resolved, That the members of the Section on Allergy of the Indiana State Medical Association promise their support in helping train these men, inasmuch as properly treated allergy patients seldom require hospitalization (such as the prevention of status asthmaticus in most patients by proper allergic management) and most allergic problems are office or clinic problems; and be it further

Resolved, Therefore, that we shall be happy to assist in proper preceptorship programs and lectures and conferences to supplement residency training programs so that Indiana University School of Medicine will not be looked upon as a second-rate medical school because of this. Ultimately, the citizens of Indiana will greatly benefit from this and this is the reason the taxpayers support a medical school in Indiana.

Resolution No. 76-6

Introduced by: Steuben County Medical Society

Subject: ISMA AS A COLLECTIVE BARGAINING AGENT

AND

Resolution No. 76-4

Introduced by: Tippecanoe County Medical Society

Subject: FEE MEDIATION WITH INSURANCE COMPANIES

AND

Resolution No. 76-10

Introduced by: Marion County Medical Society

Subject: MEDICINE'S ROLE IN HEALTH INSURANCE AND PATIENT/PHYSICIAN CONTACTS

ACTION: Amended substitute resolution adopted in lieu of resolutions 76-4, 76-6, and 76-10. (Refer to Resolution 76-4)

Resolution No. 76-7

Introduced by: DeKalb County Medical Society

Subject: REJECTION OF CONTINGENCY FEE CONCEPT

HOUSE ACTION: Not adopted.

Whereas, The contingent legal fee is utilized by attorneys in most malpractice suits; and

Whereas, The utilization of such a fee system contributes to the acceptance by

attorneys of many non-meritorious cases; and

Whereas, Such a fee system also prompts some attorneys to magnify the nature of their clients' injuries in order to win high awards; and

Whereas, The aforementioned points contribute to the growing complications of medical malpractice as well as to professional liability problems of other professional groups; now, therefore, be it

Resolved, That the DeKalb County Medical Society, in uniform agreement, presents to the Indiana State Medical Association this resolution and requests that the ISMA record its rejection of the contingency fee concept in suits against the medical practitioner and all other professional groups in the state of Indiana; and be it further

Resolved, That the ISMA work through the appropriate legislative and other channels to implement the objectives of this resolution.

Resolution No. 76-8

Introduced by: Marion County Medical Society

Subject: ETHICS IN MEDICAL LIABILITY CASES

HOUSE ACTION: Sponsor granted permission to withdraw Resolution 76-8.

Resolution No. 76-9

Introduced by: Marion County Medical Society

Subject: ESTABLISHMENT OF SECTION ON NEUROLOGICAL SURGERY

HOUSE ACTION: Not Adopted.

Whereas, Neurosurgical care has become an integral part of medical care delivery system in Indiana and the nation; and

Whereas, The neurosurgeons of Indiana are concerned with the recruitment and retention of qualified neurosurgeons for the citizenry of Indiana; and

Whereas, The American Medical Association, recognizing the need to provide neurosurgical physicians a forum within the federation, has established a Commission on Neurological Surgery; and

Whereas, The American Medical Association of Neurological Surgeons is an active national organization for neurosurgical physicians; therefore, be it

Resolved, That the House of Delegates of the Indiana State Medical Association establish an official Section of Neurological Surgery of this Association.

Resolution No. 76-10

Introduced by: Marion County Medical Society

Subject: MEDICINE'S ROLE IN HEALTH INSURANCE AND PATIENT/PHYSICIAN CONTACTS

AND

Resolution No. 76-4

Introduced by: Tippecanoe County Medical Society

Subject: FEE MEDIATION WITH INSURANCE COMPANIES

AND

Resolution No. 76-6

Introduced by: Steuben County Medical Society

Subject: ISMA AS A COLLECTIVE BARGAINING AGENT

ACTION: Amended substitute resolution adopted in lieu of resolutions 76-4, 76-6, and 76-10. (Refer to Resolution 76-4)

Resolution No. 76-11

Introduced by: Board of Trustees, St. Joseph County Medical Society

Subject: ISMA REPRESENTATIVE TO HEALTH SYSTEMS AGENCIES

HOUSE ACTION: Not Adopted. Referred to the Board for development of a statewide plan of surveillance, communication and coordination of all information pertaining to HSAs and PSROs.

Whereas, The Health Planning and Resources Development Act, (PL 93-641) has become law and Health Services Agencies (HSAs) are being formed and funded; and

Whereas, The HSAs in Indiana are already developing many planning programs and initiating Health Care Projects which will affect both physicians and their patients; and

Whereas, HSAs will also be associated with PSROs and other governmental projects and organizations; and

Whereas, Physicians are in a difficult minority position on the consumer oriented boards and cannot be expected to be fully acquainted with all HSA activities; and

Whereas, Physicians on the HSA boards do not officially represent organized medicine and are not in a position to provide all necessary communication with each County Medical Society; therefore, be it

Resolved, That the ISMA apply a full-time representative to each (total 3) HSA, and that this representative be acquainted with all HSA activities and inform and advise the county medical societies of the various projects as they arise, and he represent the physician as the HSA develops programs and he will attempt to achieve proper physician representation on committees and at appropriate meetings, and he will be directly responsible to all county medical societies associated with the specific HSA involved; and it further

Resolved, That each of the representatives be hired and guided by the ISMA, but be responsible to the majority members of the county medical societies in the specific HSA.

Fiscal Note: Cost of implementation would depend upon the salary established for each representative and associated expenses. Total maximum expenditure, $90,000, although it could be reduced to approximately half this cost if part-time people are employed.

Resolution No. 76-12

Introduced by: Owen-Monroe County Medical Society

Subject: COUNTY SOCIETY DELEGATE APPORTIONMENT

HOUSE ACTION: Not Adopted.

Whereas, The Owen-Monroe County Medical Society has 112 doctors, the distribution being 110 from Monroe County and 2 from Owen County; and

Whereas, This represents a tremendously unequal distribution of physicians; and

Whereas, The present Constitution and Bylaws, Chapter IV, Section 2, states "except that where a component society is made up of physicians of more than one county, each county shall be entitled to at least one delegate and one alternate delegate who shall be a resident of the county he represents as a delegate or alternate delegate and who shall be selected by the physicians residing in such county"; and

Whereas, This provides unequal representation in regard to county boundaries; therefore, be it

Resolved, That Chapter IV, Section 2, be deleted and delegates and alternate delegates from each county medical society be chosen without regard to county boundaries.

Resolution No. 76-13

Introduced by: ISMA Commission on Public Relations

Subject: ACCOUNTABILITY SESSION

HOUSE ACTION: Not Adopted.

Whereas, The Commission on Public Relations feels the general public needs to know their views on health care are

respected and solicited; and

Whereas, The Commission on Public Relations feels there is need for a mechanism for the general public to express their opinions on Indiana health care, both good and bad; and

Whereas, The Commission on Public Relations feels there is a need for the State Medical Association to know what these opinions are, therefore, be it

Resolved, That the House of Delegates of the Indiana State Medical Association vote favorably to include an accountability session as part of the annual meeting; and be it further

Resolved, That the committee appointed to listen to the general public be instructed that they are not to debate or discuss any issue brought before them, and be it further

Resolved, That any item they feel is noteworthy should be reported to the House of Delegates for action or information.

Resolution No. 76-14

Introduced by: ISMA Commission on Medical Services

Subject: BILLING PROCEDURES UNDER MEDICAID

HOUSE ACTION: Adopted as amended.

Whereas, Billing procedures under the Medicaid program are complex; and

Whereas, This complexity is especially noticeable in billing for nursing home care and involves both the filing of forms for Medicare and Medicaid; and

Whereas, The intricacy of the billing procedure has resulted in a quagmire of confusion leaving physicians without realistic guidelines, and the Medicaid administration does not offer a consistent voice in explaining the regulations for billing; and

Whereas, Such confusion requires repetitive filing of complicated forms; and

Whereas, Such confusion effectively deters many physicians from participating in the Medicaid program because of the inefficient use of time, overutilization of personnel, and general loss in economies for the government, the physician, and the patient; therefore, be it

Resolved, That the Indiana State Medical Association take appropriate steps in cooperation with the Indiana Department of Public Welfare and the Medicaid fiscal intermediary to develop a simplified, practical billing procedure.

Resolution No. 76-15

Introduced by: ISMA Commission on Medical Services

Subject: PATIENT VISITS MANDATED BY MEDICAID

HOUSE ACTION: Adopted.

Whereas, The Medicaid program mandates that a physician with patients in a skilled nursing home see each of them at least every 30 days; and

Whereas, The same program requires the physician to evaluate every 60 days the patient in an intermediate care facility; and

Whereas, Such mandates depreciate the physician's professional judgment to provide the necessary medical care for patients in nursing homes; and

Whereas, The individual patient's condition requires an exercise of professional judgment not lending itself to standardization of visits by the physician; and

Whereas, In honoring these regulatory mandates, there has been engendered considerable misunderstanding, inexpedient evaluations by the Medicaid administration, and loss of compensation for such visits; therefore, be it

Resolved, That it be a matter of record that the Indiana State Medical Association opposes such mandatory visits as abrogating professional judgment in the provision of patient care and that necessary action will be initiated to eliminate this mandate from the regulations.

Resolution No. 76-16

Introduced by: ISMA Commission on Medical Services

Subject: UTILIZATION REVIEW COMMITTEE

HOUSE ACTION: Adopted as amended.

Whereas, Many Indiana physicians are currently serving on utilization review committees for nursing homes; and

Whereas, Medicaid regulations require periodic patient review to determine the classification of patients as to their need for care in skilled or intermediate care nursing homes; and

Whereas, Once the classification of patients is completed, it is reviewed by government representatives; and

Whereas, Upon review, these classifications are, not infrequently, declared to be improperly determined; and

Whereas, Such data-based reclassifications by others than the utilization review committee are deemed an unwarranted usurpation of the professional judgment of physicians familiar with the patient's condition and needs; therefore, be it

Resolved, That the Indiana State Medical Association communicate with the appropriate government bodies involved in the administration of Medicaid and advise them that steps should be taken to insure the finality of the utilization review committee's action; and be it further

Resolved, That the Indiana State Medical Association communicate with the appropriate government agencies and request that steps be taken to preserve the final judgment of the utilization review committee's action.

Resolution No. 76-17

Introduced by: Ninth District Medical Society

Subject: ISMA DUES INCREASE FOR FUNDING OF TEL-MED

HOUSE ACTION: Adopted as amended.

Whereas, The Indiana State Medical Association's Tel-Med program has become its greatest and most successful public relations service; and

Whereas, An average of 600 tapes per day are requested and played; and

Whereas, Schools, church organizations and the general public at large have accepted and used this service; now, therefore be it

Resolved, That a $25 voluntary contribution by the membership be continued for one more year; and be it further

Resolved, That the Board of Trustees be instructed to investigate additional means of funding and operation of the Tel-Med program, including the use of Foundations.

Resolution No. 76-18

Introduced by: Lake County Medical Society

Subject: LEGAL PROTECTION FOR PHYSICIANS PERFORMING HOSPITAL MEDICAL STAFF FUNCTIONS

HOUSE ACTION: Adopted as amended.

Whereas, there is considerable concern that the individual physician, performing various hospital medical staff functions, may be personally liable for such actions; and

Whereas, there is an increasing demand by hospitals on its medical staff to participate in such activity, notably in Utilization Review; and

Whereas, current Indiana law provides immunity for physicians only for retrospective review, while legislation in a number of other states includes both retrospective and concurrent review; and

Whereas, relatively few hospitals have provided "hold harmless" resolutions and/or extensions of their own professional liability insurance policies to embrace the activities of the medical staff officers and committees; now, therefore be it

Resolved that the House of Delegates urges the Commission on Legislation to prepare and seek adoption in the 1977 Indiana General Assembly, laws to provide total immunity for physicians from personal liability for services rendered as officers and committee members on hospital medical staffs; and be it further

Resolved that the Indiana State Medical Association seek immediate help from the Indiana State Hospital Association in obtaining protective action from the hospitals in the adoption of "Hold Harmless" resolutions and/or the extension of the institutions' professional liability insurance to protect physician staff members from personal liability for their actions as officers and committee members on hospital and extended care facility staffs.

Resolution No. 76-19

Introduced by: Fort Wayne-Allen County Medical Society
Subject: RESTRICTION ON ISMA HEALTH INSURANCE COVERAGE

HOUSE ACTION: Adopted as amended and referred to the Board of Trustees.

Whereas, There are many forms of group insurance and other benefits available to physicians through their membership in the Indiana State Medical Association and the American Medical Association; and

Whereas, These benefits result in substantial savings to those physicians who participate; now, therefore, be it

Resolved, That insurance companies providing group policies exclusively for ISMA members and their families be asked to provide those coverages only to physicians who are current members of ISMA; and be it further

Resolved, That our AMA Delegates recommend a similar action for those group policies sold to AMA members; and be it further

Resolved, That this not be construed to deny survivors the benefits deserved.

Resolution No. 76-20

Introduced by: Board of Trustees, St. Joseph County Medical Society
Subject: TRUSTEE COMMUNICATION TO MEMBERSHIP

HOUSE ACTION: Adopted as amended.

Whereas, The trustee of the medical district may wish to convey important and necessary information and announcements to the members of his district; and

Whereas, There is no reasonable vehicle available for disbursing such information at low cost; and

Whereas, Such communication would provide some contact with the district society members and its leadership; and

Whereas, We should attempt to strengthen the district concept and its functions, therefore be it

Resolved, that the trustee be encouraged to submit at least two communications, but not more than four per year to the ISMA for distribution to his individual district members, thus resulting in needed communications.

FISCAL NOTE: The cost of typing and duplicating communications but without postage (approximately $450.00).

Resolution No. 76-21

Introduced by: Board of Trustees, St. Joseph County Medical Society
Subject: UTILIZATION OF ISMA MAILING FACILITIES

HOUSE ACTION: Adopted as amended.

Whereas, The ISMA provides free posting to any county medical society that requests service; and

Whereas, The cost of preparation and mailing of materials is rapidly increasing; and

Whereas, If all county societies wish to enjoy this free service without restriction to the number and weight of materials sent, it would create considerable inequities between county societies; and

Whereas, The ISMA headquarters would require more staff and room for such operations; therefore be it

Resolved, That county societies wishing to take advantage of such services pay a fee equal to the cost of services rendered, except for the one free mailing per year for each district medical society, which would represent an exception.

FISCAL NOTE: Cost reduction only

Resolution No. 76-22

Introduced by: Board of Trustees
Subject: STUDENT MEMBERSHIP IN ISMA

HOUSE ACTION: Not adopted in lieu of changes in the ISMA Constitution and Bylaws.

Whereas, In the Constitution and Bylaws of the Indiana State Medical Association, "Student Members" are defined as "students who hold active membership in the Indiana Chapter of the American Medical Student Association;" and

Whereas, The Board of Trustees of ISMA after careful review of the positions taken by the American Medical Student Association, have found that the beliefs of this organization are not in the best interest of ISMA and that therefore the definition is restrictive to students who elect not to belong to AMSA: and

Whereas, There are many students who would benefit from membership in the ISMA and who desire to belong; now, therefore, be it

Resolved, That instead of student membership in ISMA being contingent upon membership in the American Medical Student Association, any student enrolled in an accredited medical school in the state of Indiana should be eligible to join the Indiana State Medical Association; and be it further

Resolved, That an active dues-paying medical student section be established; and be it further

Resolved, That the Constitution and Bylaws of the Association be changed accordingly.

Resolution No. 76-23

Introduced by: Third District Medical Society
Subject: IMMUNITY IN UTILIZATION REVIEW

HOUSE ACTION: Adopted.

Whereas, Utilization review has become a part of the practice of medicine; and

Whereas, More than one half of the states have enacted statutes to provide immunity from liability to hospital medical staff and medical society peer review committees; and

Whereas, In such provisions there is no consideration given to immunity of the physician whose patient records are being reviewed; and

Whereas, A physician in good faith follows the direction and determination of his utilization review committee; and

Whereas, In the event this determination by his peers may subsequently result in litigation; and

Whereas, In the course of such proceedings the patient's physician is held legally responsible and the utilization review committee is held legally exempt from responsibility; now, therefore, be it

Resolved, That the ISMA and the AMA seek recourse through legislation to protect the practicing physician who has in proper conscience pursued a course of hospitalization and treatment for his patient and subsequently followed the recommendation of his utilization review committee pertaining to additional hospitalization or dismissal of the patient from the hospital.

Resolution No. 76-24

Introduced by: St. Joseph County Medical Society
Subject: CATASTROPHIC INSURANCE

HOUSE ACTION: Adopted as amended.

Whereas, The cost of the advanced medical technology today to sustain people over a long term following a catastrophic illness or accident is substantial and cannot, in many instances, be supported by most families of even substantial means; and

Whereas, This burden is often poorly distributed amongst the hospitals; now

therefore be it

Resolved, That the Indiana State Medical Association Board of Trustees urge labor and management, government, and all persons to obtain catastrophic insurance under the current insurance policies —to protect from financial stress from catastrophic illness; and be it further

Resolved, That the ISMA Board of Trustees be instructed to work for the development of such a program of catastrophic insurance in the private sector which would be available to all of the citizens of the state of Indiana and take the lead in publicizing this program and assuring the coverage of all citizens in Indiana.

Resolution No. 76-25

Introduced by: St. Joseph County Medical Society
Subject: SUPPORT FOR COUNTERSUIT

AND

Resolution No. 76-3

Introduced by: LaPorte County Medical Society
Subject: CREATION OF A COUNTERSUIT FUND

HOUSE ACTION: Substitute resolution adopted in lieu of resolutions 76-25 and 76-3. (Refer to Resolution 76-3)

Resolution No. 76-26

Introduced by: Fort Wayne-Allen County Medical Society
Subject: MEDICARE AND MEDICAID INVESTIGATIONS

HOUSE ACTION: Adopted as amended.

Whereas, There are currently investigations involving Medicaid and Medicare reimbursement proceedings; and

Whereas, There have been indictments of some and allegations of possible wrongdoing by other health care providers; and

Whereas, There has been wide public speculation as to the results of these findings; now, therefore be it

Resolved, By the Indiana State Medical Association that: (1) the Indiana State Medical Association condemns any type of fraud connected with reimbursement for health care whether in the public or private sector, and that (2) any member convicted of such fraud will be dealt with in accordance with Indiana State Medical Association Constitution and Bylaws, (3) the Indiana State Medical Association objects to unsubstantiated speculation as to the guilt of any of its members and, in particular, to allegations that significant numbers of its members are involved, (4) the Indiana State Medical Association again states its opposition to government regulations which are poorly conceived, written in a confusing manner, and often difficult to interpret, and which involve repeated and extensive paper work to secure reimbursement for the patient. While the Indiana State Medical Association does not condone wrongdoing on the part of any of its members, the confusion and endless regulations surrounding publicly administered health care plans have contributed to the current scandal and public dismay regarding these plans.

Resolution No. 76-27

Introduced by: Grant County Medical Society
Subject: COUNTERSUITS, RECOVERY OF EXPENSES AND FEES

HOUSE ACTION: Adopted.

Whereas, A 1976 **Nebraska** statute provides that upon application the court has discretion to award to a prevailing party "the reasonable costs of preparation and trial including reasonable attorney's fees and the reasonable loss of earnings . . . occasioned by the trial if the court finds that the losing party did not have a reasonable chance of recovery or a reasonable chance of a successful defense." (L.B. 434, approved 4/6/76); and

Whereas, A 1975 **Pennsylvania** statute provides for an appeal from a decision of a compulsory arbitration panel. If the court finds that the appeal was "capricious, frivolous and unreasonable, then the appellant shall be liable for all costs of arbitration and trial . . ." (H.B. 1367, Act III, Laws 1975); and

Whereas, An **Illinois** statute as amended in 1976 provides that "allegations and denials made without reasonable cause and found to be untrue, shall subject the party pleading them to the payment of reasonable expenses, actually incurred by the other party by reason of the untrue pleading, together with a reasonable attorney's fee . . ." The amendment eliminated an additional requirement for recovery that such allegations must have been made in bad faith. (H.B. 3957, P. A. 79-1434, Laws 1976); and

Whereas, A **Rhode Island** enactment provides that if a mediation panel finds no physician liability and a final judgment of no liability has been entered by a court "after all appellate processes have been exhausted, then the court may impose upon the plaintiff all costs incurred in said action by the defendant in defending against said claim, including costs of the panel's proceedings and reasonable cost of attorneys fees." (H. B. 7796, Chap. 244, Laws 1976); therefore, be it

Resolved, That the Commission on Legislation of ISMA study this type of legislation and if possible, work to obtain similar legislation in Indiana.

Resolution No. 76-28

Introduced by: Fort Wayne-Allen County Medical Society
Subject: CERTIFICATE OF NEED

HOUSE ACTION: Substitute resolution adopted in lieu of Resolution 76-28.

Whereas, ISMA is opposed to any certificate of need or certificate of public necessity legislation that could affect the health care providers and recipients in Indiana; and

Whereas, We feel that certificate of need legislation as proposed violates the rights of individuals and institutions to engage in free enterprise; and

Whereas, Such a bureaucracy would place undue powers in the hands of individuals not elected by the citizens of our state; and

Whereas, The entire matter is presently in litigation; therefore, be it

Resolved, That the Indiana State Medical Association oppose any state legislative effort to develop any certificate of need or public necessity legislation.

Resolution No. 76-29

Introduced by: Board of Trustees
Subject: DEFINITION OF DEATH

HOUSE ACTION: Adopted.

Whereas, The ISMA Study Committee for the Definition of Death feels it is imperative that the Indiana legislature enact a suitable definition of death to protect the physician, in both criminal and civil law; therefore, be it

Resolved, That the Indiana State Medical Association recommend that each hospital medical staff in the state establish a committee to aid in diagnosis of brain death; and, be it further

Resolved, That the ISMA Board of Trustees seek to introduce legislation which states:

> "Death" means that a person will be considered dead if in the announced opinion of an attending physician, based on ordinary standards of medical practice, the patient has experienced an irreversible cessation of spontaneous respiratory and circulatory functions; or, in the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, the patient has experienced an irreversible cessation of spontaneous brain functions.

Presidential Resolution

HOUSE ACTION: Adopted by acclamation.

Whereas, The presidency of the Indiana State Medical Association requires an enormous amount of time requiring great sacrifices by family and foregoing a great deal of personal freedom; and

Whereas, The current president has given of himself unselfishly, and in many instances above and beyond the call of duty; and

Whereas, He has exhibited a great capacity for leadership by drawing all physicians into a strong, united Association; and

Whereas, Because of his strong leadership and farsightedness, the Association has increased its membership and stayed on top of all legislative proposals which could affect the way physicians practice in Indiana; now, therefore, be it

Resolved, That this House of Delegates express its deep thanks and appreciation to Vincent J. Santare, M.D., for this outstanding year and wish him well in all future endeavors.

Resolution to Speaker of House

HOUSE ACTION: Adopted by acclamation.

Whereas, William R. Cast, M.D., of Fort Wayne, has served this House of Delegates as vice-speaker and speaker; and

Whereas, His abilities to articulate the parlimentary issues and to manage the affairs of this House of Delegates will be temporarily unavailable to this organization due to other responsibilities; now, therefore, be it

Resolved, That this House of Delegates express its sincere gratitude and appreciation to Doctor Cast for his leadership and direction which he has generously given to this assembled body.

Resolution to Staffs and Others

HOUSE ACTION: Adopted by acclamation.

Whereas, The 127th Annual Convention of the Indiana State Medical Association is drawing to a very successful close; and

Whereas, The staff of the Indiana State Medical Association has worked tenaciously, and in many instances in excess of the normal work day, assisting the officers and Convention Arrangements Commission in planning and insuring this convention was run in an efficient manner; and

Whereas, The Indianapolis Hilton staff worked harmoniously with ISMA staff in setting up this convention, and

Whereas, The Indianapolis Convention Bureau provided persons, at no cost, to assist ISMA staff in accomplishing the many tasks that go along with any convention of this size; and

Whereas, The State Board of Health provided equipment and staff which helped make this a very successful convention; and

Whereas, The members of the Convention Arrangements Commission labored many long hours in putting together a successful three-day convention; and

Whereas, A financial contribution has been received from Blue Cross and Blue Shield of Indiana, Bristol Laboratories, Ciba Pharmaceutical Company, Immke Circle Leasing, Inc., Eli Lilly & Company, Mead Johnson Laboratories, The Medical Protective Company, Merck Sharp & Dohme, A. H. Robins Company, The Upjohn Company and Wyeth Laboratories to assist with the education program at the Convention; now, therefore, be it

Resolved, That this House of Delegates extend a hearty well done to the ISMA staff and members of the Convention Arrangements Commission; and, be it further

Resolved, That this House also extend thanks and appreciation to the Indianapolis Hilton Staff, State Board of Health, Indianapolis Convention Bureau and all those who contributed to the successful educational program during this 1976 Convention.

Place of Future Annual Conventions

1977—Indianapolis—October 10-14
1978—French Lick—October 14-19
1979—Indianapolis—October 8-10
1980—Indianapolis—dates to be set by Board of Trustees
1981—Indianapolis—dates to be set by Board of Trustees

Adjournment

The House of Delegates adjourned sine die at 4:55 p.m., Tues., Oct. 12, 1976.

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THE 1976 ROSTER OF MEMBERS

For convenience in handling and reasons of economy, this year's Roster was published as a Supplement to the June issue and was printed from information carried on our computerized Master File.

Additional copies of the Roster may be ordered at a cost of $5.00. Copies of the June Yearbook are available at $3.00. Please send check with order.

COMMERCIAL ANNOUNCEMENTS

PHYSICIAN OPENING IN INDIANA REHABILITATION SERVICES INDIANA REHABILITATION SERVICES has openings for physicians in its various divisions. Interested persons should contact Dr. Walter E. Deacon, #1016 Illinois Building, 17 West Market Street, Indianapolis, Indiana, Telephone: 317-633-5961.

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WISH TO PURCHASE copy of book titled "William Henry Wishard, A Dactor af the Old School," by Elizabeth Wishard. Write or call THE JOURNAL, 317-925-7545.

WANTED: USED OFFICE EQUIPMENT for G.P. office. Interested in complete set-up. Reply to Box 410, THE JOURNAL.

WANTED TO BUY copy of Dr. B. D. Myers' "History of Medicine in Indiana," published abaut 1946. Write or call THE JOURNAL, 317-925-7545.

TAX DEDUCTIBLE VACATIONS for medical prafessionals. Over 500 listings of national/international meetings in the medical sciences for 1977. Send a $10 check or money order payable to Prafessional Calendars, P.O. Box 40083, Washington, D.C. 20016.

WANTED-PSYCHIATRIST ta direct the Mental Hygiene Clinic at VA Outpatient Clinic in Evansville, IN. Beginning salary up ta $45,000 depending an qualifications. 30 days vacation, 15 days sick leave, educational apportunities and many benefits. Licensed in any State. An Equal Emplayment Oppartunity emplayer. Contact Chief Medical Officer, VA Outpatient Clinic, Evansville, Indiana 47708. Telephone: (912) 423-6871.

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WANT TO BUY two copies of "One Hundred Years of Indiana Medicine," by Drs. Combs and Kiser. Write or call THE JOURNAL, 317-925-7545.

PHYSICIAN'S ASSISTANT student is seeking a future position in a primary care or surgery practice in Indiana. Prefers to work with a group practice, but would consider a private practice. Available for preceptorship from June 1 to Aug. 31, 1977, and/or for employment after graduation Aug. 31, 1977. Contact: Steven M. Trimble, 410 Columbia Dr., Apt. 2, Columbia City, Ind. 46725.

NOTICE

Commercial announcements are carried in the Journal as a special service to ISMA members. Only advertisements considered to be of advantage to members by the Journal editorial board will be accepted. Those of a truly commercial nature (i.e., firms selling brand products, services, etc.) will be considered for display type advertising.

Charges for commercial announcements are:

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Send cash with order. Average count: seven words to the line.

DEADLINE: Fifth day of month PRECEDING month of issue.

FOR SALE: AO series dual viewing microscope with 35 mm camera and carrying case. Excellent condition. About 5 years old. Recently appraised value $1,825.00. Phone 812-279-5522.

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